



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

National Health Service

Twentieth Anniversary Conference

Report

*Church House, Westminster, London, S.W.1
Thursday and Friday, 4th and 5th July, 1968*

LONDON

HER MAJESTY'S STATIONERY OFFICE

1968

SBN 11 320049 8

FOREWORD

The National Health Service came into existence on 5th July 1948 under the provisions of the National Health Service Act 1946.

Twenty years later, the Rt. Hon Kenneth Robinson, M.P., then Minister of Health, held a two-day conference in Church House, Westminster, London, S.W.1. The purpose of the conference was not only to mark a notable anniversary, but also, more importantly, to help to shape and fit the Service for the tasks ahead. The Minister's final words to the conference were "forward to the 1970s".

Seven papers were presented to the conference and are reproduced in this report together with a summary of the points made in the discussion which followed each paper. About 300 persons attended the conference, representing the very many who will have an important part to play in the future of the National Health Service.

This report has been produced so that discussion of the papers can continue in a wider forum with discussion on the proposals for the revision of the administrative structure of the National Health Service.

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INTRODUCTION

The Rt. Hon. Kenneth Robinson, M.P., Minister of Health

The members of the conference were welcomed by Mr. Robinson. He said that those present had come from the hospital service, the family practitioner and local authority services, the academic world and a variety of voluntary organisations. A very wide range of interests was represented and all of them would be focussed on the interests of the patient. The conference was intended to be forward looking and to direct itself to the tasks ahead. It was right that the energies of the conference should be directed in this way because what was said at the conference would complement the discussions on tentative proposals for the revision of the administrative structure of the National Health Service which were very soon to be published in the form of a Green Paper.¹ At the same time it was right that the effort and devotion put into the National Health Service by many thousands of people over the past twenty years should be recognised. The country owed these people its gratitude.

Mr. Robinson recalled that in 1948 the Minister of Health was the late Aneurin Bevan and it was especially fitting that the opening address at the conference should be given by his widow, Miss Jennie Lee.

¹ Published by H.M.S.O. on 23rd July 1968. "The Administrative Structure of the Medical and Related Services in England and Wales".

OPENING ADDRESS

The Rt. Hon. Jennie Lee, M.P.,
Minister of State, Department of Education and Science

It is a good rule in public life not to talk to an audience that knows a great deal more than you know yourself. I am very conscious of the fact that you are here because you have a history of service and enormous expertise covering every field of the National Health Service. As you know, my time and my energies are spent in other directions. I keep a weather eye open for some of your main decisions. I am always delighted if I think that your Minister is getting enough of his own way with his colleagues when he goes asking for cash. I am always ready to console him if I think perhaps he ought to have had a bit more; but that is very much on the side.

You have been gracious enough to invite me here because you know that when the Health Service was being initiated I was in the heart of the struggle; I knew every nuance, every move, inside and outside; I knew where the allies were; I knew where the opposition was. It is proper that we should keep looking ahead, not looking backwards. But we do not know where we are going unless we know where we have come from.

Of course, Health Service in this country did not begin in the year 1948. Many of us have associations with the between-the-wars Health Service; a great patchwork, a good deal of good intentions, a great deal of inadequacies. I was always very proud of the fact that in the Fife coalfield it was my grandfather who collected twopence a time from the men at the end of the week to pay for their own doctor. That was their own self-help and their own Health Service in those far off days. We all have memories and associations with the beginnings and what we did in a patchwork atmosphere.

But when the Second World War came its suffering and sacrifices gave us a family feeling; we were fighting Hitler together. In that atmosphere the National Government in the year 1943 declared its acceptance of the assumption that a comprehensive Health Service for all purposes and all people should be established. That was part of the "grand folly" of a moment in the War when we had no objective evidence to justify our belief that we were going to defeat Hitler. This goes back to 1943. Our cities were being blitzed; our industries were being disorganised in order that they should provide the munitions that could not come across the Atlantic because of the sinkings. In that atmosphere we were essentially saying that we had a faith to fight for and that we wanted the world after 1945 to be more just and more compassionate than it had been in the between-war years. So it was the National Government in 1943 that set out the first statement, and we know Lord Beveridge's part in all this. But it was a Labour Government, and it was Aneurin Bevan who was the Minister in that Government, entrusted with carrying out this intention. I have here what were the intentions of the National Health Service Act. Perhaps it is quite useful that from the heat, the dust, and the arguments, from your preoccupation with day-to-day difficulties, we should just pause for a moment and see what was the basic philosophy. The dignity, the status, and the authority of the Health Service are rooted in its basic philosophy. If the philosophy goes, everything goes.

As you know, that philosophy was that we should pay when we were well in order that when illness came, irrespective of age, sex, colour, circumstance, we should have the full panoply of medical knowledge at our service. That was the

spirit of war-time Britain. That was our faith and our pride in one another. This is what we set out to do. So by the time the Act is formulated we say no unnecessary uprooting of established services; what was good should be preserved, adapted, extended, and moulded together and incorporated in a comprehensive organisation. We said this was to ensure that everybody in the country irrespective of means, age, sex, or occupation should have equal opportunity to benefit from the best and most up-to-date medical and allied services available. We were going to provide for all who wanted a comprehensive service covering every branch of medical and allied activity, and we were to encourage the provision of early advice and the prevention, not merely the treatment, of ill health. That still stands.

Our acceptance of total responsibility for a full range of health facilities for all the people was the essential first step in forming new patterns of service, blending care at hospital, care at home, linking the work of the family doctor with the help of the home nurse, the health visitor, the midwife, and the medical officer of health.

Now, Mr. Minister, I come to the part where you are involved because now we say that these new patterns have in turn put strains upon the administrative structure. This is under review and of course this will be discussed on a later occasion. I know that I am telling you facts of which you are already well aware, but if we have got to get this in its proper philosophical and historical setting and against all the current criticisms of the Health Service and of your individual and collective contributions to it, it is well for it to be more widely known that at the present day we are now treating over 70% more in-patients per year in our hospitals than in 1949; and we are doing that with very little change in the number of beds and with over 25% more out-patients. That is quite something.

We have achieved large increases in numbers of doctors and nurses. We do not have enough. We know all the problems. I had nine days in hospital in the middle of winter, and I am an expert on what the young nurses feel that they ought to have; I agree with them. I know quite a lot about the young doctors and what their problems are. But nevertheless with all the difficulties and with all the shortcomings, we have many more nurses and doctors in the Service.

On the domestic front, domestic help is looking after three times as many people at home as in 1945 and about half as many again are attended by home nurses; and, very important, in recent times there are over six times as many training centres for the mentally subnormal as formerly. If you want to be fair about the Health Service, you have to consider that with a relatively small increase in doctors and nurses compared with the need, all this additional service is being given. When we come to the total figures, I see that 700,000 people are now being employed; when it was introduced the total number was 340,000.

It is good for us to begin on a positive note of this kind but my contribution, if any, is perhaps to remind you that nothing worth while is either begun or sustained without immense effort. We knew what we wanted to do after the War, but you have to pay for welfare as well as for warfare and, of course, we had lost so much during the War. All over the world people looked amazed. They observed this incredible island; it ought to have been brought to its knees during the War; it was not; there it was. It was planning a Service which wealthier neighbours like America said they could not afford. I cut out the word "free" Health Service because nothing could be more absurd; it is not a free Health Service.

One of the problems—and this is a moral and social problem as well as an

economic problem—is how the Health Service has to be paid for. I am not going to intervene, I am not qualified to do so, in any of the immediate discussions that are going on, but if we are concerned with the philosophy of the Health Service there was never any doubt at all about it that we wanted the cost of it to be totally paid for by the Exchequer in the same way as defence and other great national services. But Aneurin Bevan did not get all his own way; no Minister does, not even me. We all try; we do our best; but at the end of the day you have got to see just how much progress you can make. There are other needs; there are other priorities. And so, of course, there is a certain resentment in Britain today; you will find that if you go around the factories and industrial quarters. They say: "Good gracious, we pay for the Health Service as taxpayers; we pay insurance every week"; $3/10$ altogether— $3/2$ for the men and 8d. for the employer; $3/2$ for the women, with $2/6$ deducted from women and $1/7$ from juveniles. Then they know from local taxation they pay half the cost of local health and welfare services. The total cost now is £1,494 million. So that we are up against here a problem in priorities.

I was very much impressed by hearing some very splendid American friends say: "We made a mistake after the Second World War. We came out of it in very comfortable economic circumstances, not realising that if you leave considerable numbers of your young under-educated, under-doctored, badly housed, you are going to have an explosion." It is not for us to interfere in the affairs of any other country, but if we are counting what a great Service costs we have also to count the cost of not providing certain services. It is a benediction when you see a well cared for young mother and her child; when you know that we are feeding babies before they are born; when we know we have the most vital younger generation we have ever had; when we know that we are showing more tenderness and more concern for the mentally sick than ever we have shown before.

I believe in my country being ambitious. I want us to continue to be the trend setters and the pace makers, and I am sure we can do it. Later on in your discussions you will be concerning yourselves not only with the over-all economics but the over-all organisation of the Health Service. One of the last jobs that Aneurin Bevan did was a broad plan for the reconstruction of local government. He believed that at some time we would have to look into the problem of whether the Health Service should be sustained by elected or selected representatives. This is a very difficult problem; there are problems on both sides. The Minister does not know all the people he selects; he is at the mercy of his advisers; and of course he has splendid advisers. But after all the splendour of their advice, he is still left with a certain amount of muttering in the background that perhaps the representation on some regional council or hospital committee is not as broadly representative as it should be.

Aneurin Bevan did not think that local government as it was when the Health Service was introduced could have taken the main brunt of finding the representatives, but he did visualise—and I think this will come one day—that when we have a complete reorganisation and larger units of local government that is one of the problems that will have to be looked at. But, again, it is not for me to go further into this than simply to say to you that above all when the Health Service was being fashioned Nye was impressed by the number of people who gave their devoted service irrespective of party politics, irrespective of social background.

We had one acquaintance who was a great naval power in the War; I shall

not be more specific than that. He could not believe that he was still going to be in charge of his own hospital; he believed what he read in the papers. He was so delighted to feel that this was still in his charge.

You will also remember that in those days there was a very, very fierce public controversy; you may remember some of the cartoons of that time. In some parts of the world power politics mean torture, exile, every kind of intimidation. In our kind of society it is character assassination. That word has become fashionable again. Looking at some of the old caricatures, Nye, the Minister, was presented as an uncouth, loud-mouthed, vulgar demagogue. Nye relished the fact that when he was in actual contact with his hospitals and at conferences the contrast between what he was supposed to be and what he actually was gave him a little unfair advantage over some of his critics.

He used to chuckle with delight when he would get a request from some doctors' association saying they wanted an assurance from the Minister that there would be no political interference between patient and doctor, and that they would not become civil servants. He was delighted because he had never any intention they should. There are times when you can turn some of the attacks made on a great service into an asset if you know how to do this job. The fact was that you could not get a Service of this kind operating unless you had the co-operation of the people in the Civil Service, the people in the hospitals, and the people in the regional associations, together with the great specialists.

I remember the fight to get teaching hospitals included; that was another compromise as some of you know; I can see some smiles; one day you will be told the full story. Of course, you can be an impossibilist in public life; you can say you want everything; Nye had a phrase for it. He would mutter under his breath in moments of supreme exasperation with impossibilists—"pure, the * * *, but impotent". You have got to fight with all your might for the things you believe in. But at certain points of time there are the moments when you know that if you are going to do anything at all that is positive and constructive, you have to make the best of the most conceded to you.

We had to get our wage and cost specialists in; and we did. We had to make concessions about pay beds; and we did. Nye believed in the amenity bed. But his faith was that in time we would have the co-operation of our doctors, surgeons, and specialists in every field because they would see how wonderful it was to have a Health Service that the whole world could admire which made no distinction between rich and poor, where you were not disadvantaged because you were poor and advantaged because you were rich, because by being rich you could not get anything better than was already being given. We all know that the main ward of one of our great general hospitals is much better than a corner in some private place. I shall say no more.

Forgive me if I have talked too long. Thank you for asking me here. It would be impertinent on my part to infringe on many of your contemporary problems; but I am very conscious of the great army of men and women who do so much. And because so many do so much on a voluntary basis, the administrative costs of the Health Service are incomparably less than the administrative costs of many of our great businesses.

In spite of all the dust, the struggles and frustrations, and all the sectional interests clamouring quite properly to be looked after more adequately, let us, 20 years after its beginning, be glad if we have played any part at all in establishing and sustaining this great Service, and let us look forward in the not too distant future to seeing the very highest of its hopes fully realised.

Session 1 Changing Medical Needs

Professor W. J. H. Butterfield, O.B.E.,
Professor of Medicine, Guy's Hospital

Introduction

All of us will be casting our minds back to the time when the Beveridge Report was published. It found me a medical student at Johns Hopkins in the States and I certainly did not imagine in my wildest dreams of glory the honour and responsibility which falls on me today, following the Minister of State, Education and Science, the widow of the great Aneurin Bevan, of whom a friend on the Wall Street Journal once said to me—"He's the most damned charming politician in the land; I say damned because I'm a Republican!"

The Beveridge Report caused a stir in America and we "exiled" young Britons were proud of its attempt to find a rational solution to the basic fact that there was much more illness among the poor, who didn't have the money to meet their health and medical needs. Liberal Americans of those days were very sympathetic towards the Report and indicated that they would watch our Health Service: its success would speed the introduction of similar legislation in their country.

Since 1948, and particularly lately, I personally don't think we've done ourselves full justice over the National Health Service. The extent to which it is appreciated by the populace has not been spelled out with sufficient clarity to convince the hard core opposition to so called socialized medicine in countries like the United States, though as you well know, legislation has been recently enacted there to bring medical care to the new poor in inflationary economies, the elderly.

Why hasn't everyone wanted to take the National Health Service Act as a model for their own legislation? Apart from obvious opposition groups who were anxious to denigrate any improvements for sectional interests, I would like to submit that our success has been hard to recognise for various reasons to be discussed in more detail presently.

Firstly, the National Health Service has been established during the rigors of post-war economy, which has been demanding us to take a new view of our role in the world. Compared to the States, money has been woefully short. And being established among, I won't say in competition with, many other social and economic developments has made it particularly difficult to isolate, measure or validate our progress. If we try to take too much credit for the National Health Service for improved health, we will only miff other groups who have been contributing to improved conditions, the architects and building contractors, the agriculturists, fishermen and nutritionists, safety officers and so on. We should take pride and satisfaction from being part of the country's whole success in rebuilding itself since World War II.

There has been, then, a great exchange of ideas, resources and techniques between the Health Services and society generally. I hope to show examples briefly, such as atomic weapons stimulating the use of isotopes for medical research, and so on. Such technical developments used by the medical profession are world-wide in origin. But we should also resist any suggestion that

the National Health Service successes are due entirely to overseas research! The Minister's address is Alexander Fleming House and it was Fleming's discovery of penicillin that started the American search for new antibiotics in earth samples collected from all corners of the world! These antibiotics, and many other things, have had a profound effect in changing medical needs.

Changing Needs

What are needs? It has been defined as a condition "in which something important is lacking", or "requiring some extraneous aid or addition", or a "necessity arising from facts and circumstances of a case". So changing needs will be considered here as the consequences of new facts and circumstances arising in the twenty years since the National Health Service was inaugurated.

At the outset in 1948 there was an urgent demand for medical care to deal with many diseases of poverty—such as hernias, infectious diseases, poor teeth, etc. The main changes which have affected our view of medical needs since are concerned with: the *population*, its size, age structure and the effects of immigration, the *social* changes going on alongside medical developments—such as housing improvements, educational changes, road building—and the *technological* innovations such as "ersatz" wartime objects which paved the way to the plastics industry. The original situation has given way in large part to new needs, many of which can be attributable not so much to poverty, but ignorance—that is, not realising that smoking aggravates bronchitis and is associated with a risk of lung cancer, that speed kills and maims, that obesity predisposes to hypertension and diabetes, that corsets may cause varicose veins and so on.

It is important to stress that the developments going on in all these fields—social, technological and medical—are closely interwoven. We can be proud indeed of our contribution to research; it has been highly significant, as is witnessed by our numerous Nobel Laureates. But research has been international and medicine has absorbed useful advances irrespective of the country of origin in its attempt to improve the quality of medical care. How have these various effects interacted and changed medical needs?

Population changes

Regarding the population the main changes have been an increase in total numbers in Great Britain. For example for England and Wales the population rose between 1948 and 1967 from 43.5 million to 48.4 million (+10%). This associated with increased numbers of those age groups who require most medical attention, the young and the elderly—a rise between 1951 and 1966 from 9.6 to 10.8 million in children 0–14, from 10.6 to 11.8 million in persons 45–64, from 4.8 to 5.9 million for those over 65. There has also been large scale immigration first from Europe, then from the West Indies and most recently from Asia: in the 1951 census, some 1.0 million persons were born overseas, in 1966 1.8 million. The new medical needs are clear, geriatrics and to a lesser extent the services needed by immigrants—see Table I, page 19.

Social changes

Since the War, economic planning based on Keynesian principles has been associated with a great deal of social legislation. Major programmes for rehousing have been carried through by successive Governments. The total number of dwellings per 10 persons has risen steadily from 2.6 at the end of the

War to 3·3 today. At the same time the number of hospital beds has remained steady but nevertheless recent operational research suggests that many hospital patients could be treated as well at home—and in view of the expense of hospital in-patient treatment—each case costs £60 or more a week—the changing needs are clearly more domiciliary and out-patient care.

Technological changes

One cannot do proper justice to the technological developments which have so greatly improved potential medical care and made possible such strides as open heart surgery and complex metabolic and endocrinological investigations. But it is important to remember that the research which yielded the reviled atomic bomb also accelerated isotope developments and made them available for the study of individual metabolic pathways such as the incorporation of ^{14}C -thymidine into DNA—and how, in this sort of painstaking way, it has been possible to assemble a picture of the complex biochemical processes in the cells of our bodies and understand the breakdown of carbohydrates, the synthesis of fatty acids and cholesterol, the production of energy in the mitochondria—and so on. Electronics and solid state physics have brought in the transistor and the computer, which is being used extensively in medical research to analyse data, and in medical administration for accounting, activity analysis, nurses' rotas, inoculation programmes, etc. and plans are afoot to test the feasibility of computer record systems. Automation has provided various laboratory systems capable of performing a wide variety of biochemical estimations on blood and urine samples—and the plastics industry has provided the basis for cardiac catheters and pacemakers.

Looking at the interactions between academic and medical research, it is not difficult, therefore, to trace the relationships between isotopes, chromatographic techniques, new forms of mathematical analysis, electronics and plastics on the one hand and medicine's new knowledge about metabolism, protein structure and synthesis, immunology, DNA, RNA, viruses, spare-part and open heart surgery, intensive care and artificial kidneys.

Intensive care

All this co-operative research and development in the last 20 years has created changing needs by opening up completely new horizons of medical treatment. One can think of these as being largely at one end of the spectrum. (I like to think of them as the dazzlingly bright ultraviolet end of the visible spectrum, with its short wavelength, searing radiation!) Such newly available treatments are often intensive, expensive and very demanding of highly skilled medical, nursing and technical manpower. The sort of developments which fall into this group include transplant surgery and intensive care units for acute myocardial infarcts, or traffic accidents. *The Times* recently published a diagram showing the 35 spare parts available now. Deaths from traffic accidents for all ages have risen to 174 per million (1964), equivalent to 66% of accidental deaths, completely replacing in our statistics old time deaths from drowning: the Royal Humane Society's dream of a population able to swim has come true in our schools and swimming pools. It is ironical, however, that the same traffic deaths among reckless young people provide the healthy organs for the transplantation surgeon: among males aged 15–19 the death rate has risen since 1948 from 130 to over 500 per million, about five times as high as for girls of the same age.

Another group, much in the news, requiring expensive and intensive medical

care are the drug addicts, but although their load on the National Health Service to date has received a great deal of publicity, the numbers involved are fortunately not yet large, 1,400 in 1966. This does not detract from the appalling rise in "non-therapeutic" addicts from 60 in 1958 to about 1,000 by 1966. There is a real risk that this social problem will become more demanding in future.

Disease and the therapeutic revolution

We must now turn to look at the middle of the spectrum—the obvious diseases demanding care—which in my analogy might be regarded as visible light. This group of diseases has been greatly altered by medical research and the therapeutic revolution. The extent of the therapeutic advance is exemplified well by comparing the numbers of medicines available to doctors in 1948 with today: for example, although streptomycin and P.A.S., which were to stem the toll of tuberculosis, and Aureomycin were just being tested in 1948, there was only one antibiotic generally available then, penicillin; now we have 33. We had one adrenal steroid, corticosterone in 1948, but since then cortisone has been developed and today we have 11 useful anti-inflammatory steroids. We had 6 diuretics in 1948, the best, Mersalyl, requiring injections. Now we have 24, most of which are effective by mouth. We had no real medicines for hypertension or mental depression, but now there are 15 useful antihypertensives and 18 antidepressives. We also have 7 new useful oral antidiabetics. One could go on, but the point has been made. Under the influence of these therapeutic advances, bacterial infections are vanishing and many cases with other diseases are now treatable. Doctors need much continuing education to keep abreast of the times—see Table II, page 19. Regrettably, iatrogenic disease does occur with some of these powerful therapeutic substances: ignorance is dangerous today.

It isn't difficult to trace the effects of these developments on medical needs since 1948. Innoculations have eradicated diphtheria, the death rate for children (1-4 years) has fallen from 500 per million in 1941 to 11 per million in 1948, to less than 1 per million by 1953. The death rate from tuberculosis has fallen from some 500 per million in 1948 to about a tenth of this figure, improvements similar to those obtaining in the U.S.A., where over 10 times as much money is spent on medicine. The death rate from pneumonia, already falling with the introduction of the sulphonamides in the 1930s, has been reduced more rapidly, to 28% of that which we would have expected by now. All this is not to say that acute infection has vanished completely. Bronchitis is still a serious problem, but it is in decline and even the childhood virus diseases, poliomyelitis and measles, are being brought under control.

Changing patterns, from acute to chronic diseases

By contrast, disability caused by the chronic degenerative and debilitating diseases seems to be increasing to a serious extent. The number of deaths and discharges due to arteriosclerotic heart disease in England and Wales has risen from less than 2,000 per million in 1948 to over 10,000 today. The number of diabetics in 1948 was some 100,000, today the figure is estimated at about 1 million.

One gets an even clearer picture of the national toll of these chronic diseases from a study of proportionate costs in the National Health Service. Thus, for 1961, mental, psychoneurotic and personality disorders involved 16.2% of the

National Health Service expenditure: dental problems, 9.2%, respiratory diseases, 8.8%, cardiovascular diseases 8.4%, digestive diseases, 6.1%, injuries and accidents, 4.2%—and so on.

Or if we look at the diseases affecting attendance at work, we find the main ones causing lost working days (calculated per 1,000 persons insured per year) were, for men, bronchitis (1,600–2,000 days), arteriosclerosis and heart diseases (about 700), and for women, psychoneuroses (1,000–1,100), bronchitis (about 1,000) and rheumatism (about 900).

A final statistic which shows the change in emphasis of medical need from the old fevers to chronic debilitating disease comes from examining the expenditure by Local Authorities on mental disease; this has risen from £1.2 million in 1949 to £20 million in 1966.

Our thoughts are therefore moving out into the community and towards the other end of the spectrum which one might regard as the infra-red end, the long-wavelength radiation unseen but potentially very damaging.

Latent disease in the community

I refer, of course, to the hidden disease in our community uncovered by almost every epidemiological study where prevalence rates have usually exceeded those recorded in current statistics. The notion of the "clinical iceberg" must be well known. It was introduced to give some indication of the discrepancy between our statistics for chronic disease and the prevalences recorded in epidemiological surveys. For example, the number of recognised cases of urinary infections among females over 15 was 420 per 1,000 in 1962, the total number was estimated as 830 per 1,000: the figures for hypertension for males over 45 were 170 per 1,000 and 620 per 1,000, for glaucoma 60 per 1,000 and 340 per 1,000, for rheumatoid arthritis, 230 per 1,000 and 520 per 1,000, and so on. In each study, much latent disease has been found.

In defence of the National Health Service, on its 20th anniversary it is important to point out that *exactly the same sort of finding has been made in the U.S.A. and Scandinavia.*

One might legitimately ask if this unrecognised disease represents a real change in medical need. I believe it does. For example, consider the difference between the obvious onset of the fevers of yester-year and the insidious onset of chronic disease like varicose veins, which currently usurp 6% of our surgical beds in hospitals, or indigestion, hypertension, anaemia or diabetes. One may depict the community as being in layers of health and sickness, with the healthy at the top, those persons in the early biochemical stages of illness next, shading into the persons with symptoms. Under the old dispensation of fevers, sufferers quickly sought help for their illness. But with the chronic illnesses of today there is no clear cut start. People may take no action for years out of ignorance, or cowardice, or stoicism. And if they do take action for their illness, they may prefer to make a self-diagnosis and treat themselves at the chemist's shop rather than risk admission to hospital for investigations by going to their doctor!

Symptoms, symptoms, symptoms, or perhaps no symptoms

In a recent study of how people living around Guy's Hospital obtained their primary medical care, we found that only 5% had no symptoms, but 19% had symptoms but took no action and that of the 76% who took action, over two-thirds preferred to treat themselves! These findings—coupled with the facts that the average number of symptoms suffered was 4.5 and that 20–40% of

previously unrecognised diabetics in the Bedford Survey did not have obvious diabetic symptoms—all help to explain why there is a clinical iceberg. People may not have the textbook symptoms, or they may not report them to the National Health Service because they are ignorant of their significance, or because they hope they will “go away”.

To me, therefore, this end of the spectrum represents a potential tidal wave of demand for medical care, a wave currently being restrained partly by fear and ignorance, and partly by the wide range of across-the-counter remedies available in the chemists’ shops up and down the country—see Table III, page 20.

The needs for health education, screening for priority, research and better management

Since most of the chronic diseases can be attributed, at least in part, to maladaptations to civilisation, e.g. chronic bronchitis from smoke, or dusty work; lung cancer from tobacco and hypertension, anaemia, diabetes to over-indulgence of one sort or another, we must try to stem the tide of demand these chronic diseases are creating by a vigorous programme of health education coupled with better management of our resources. Screening for priorities, using automated laboratories to find the most needy, perhaps asymptomatic, cases for treatment is a possible step to help solve this problem, but it is a few years off yet. But unless some progress is made in these two directions, health education and screening, there is a very real risk that the proper care of the very sick may be swamped by the demand of chronic debilitating diseases.

If I went back to Johns Hopkins now, what could I say? Firstly, pride. We can be proud that the National Health Service has at least kept up with the medical Joneses, Scandinavia and N. America, despite all our other national post-war demands. We have made useful contributions in all the fields of medical research. It is my prejudice that we now face new challenges and demands upon us!

The new challenge is planning the best use of our resources to ensure that the improved techniques available get to both ends of the spectrum—which has extended so much since 1948 so that it now includes transplanted kidneys for the renal cases at one end to automated laboratories, new therapeutic substances, better welfare services or a research break-through to help in the detection or management of, say, the increasing numbers of blind elderly diabetics, at the other end.

In summary, then, needs are changing rapidly. The medical and research attack on diseases attributable to poverty and bacterial infections must be switched to diseases of civilisation aggravated by ignorance and poverty. If we have the right attitude of mind, if we collect the basic information about the real health needs to form the basis for planning our goals and so our priorities, we can move on towards improved standards of community health which would more than justify the National Health Service to everyone. In fact, this is the way to stay ahead of the Joneses!

Summary

Changing needs defined

1948

Changes — Population
Social
Technological
Research — Academic
Therapeutic
Epidemiological

Needs covering a much wider spectrum in 1968

Table I

Population Changes (England and Wales) 1948-1967			
1948	1951	1966	1967
43.5			48.4(+10%)
0-14 yrs.	9.6	10.8	(+1.2)
15-44	18.7	18.6	
45-64	10.6	11.8	(+1.2)
65+	4.8	5.9	(+1.1)
80+	.6	1.0	(+.4)
Born overseas	1.0	1.8	(+.8)
Changing needs: Geriatrics			
Immigrants			

Table II

Examples of Therapeutic Advances				
Medicines available	...	...	1948	1968
Antibiotics	...	...	1	33
Corticosteroids	...	...	1	12
Diuretics	...	...	6	24
Antihypertensives	...	...	(2)	15
Antidepressives	...	...	(2)	18
Oral Antidiabetics	...	...	0	7
Changing needs	—	more cases treatable medical education (iatrogenic disease)		

Table III

General Conclusions
The Widening Spectrum of Need, 1948-1968

	Hidden Chronic Disease	Apparent Disease	Intensive Care
1948	Very little known	+++	Not possible
1968	Much recognised	++	Growing demand

(Compare to Physical Spectrum)
(infra-red radiation)

(visible light)

(ultraviolet light)

* * * *

Professor W. W. Holland of St. Thomas' Hospital, opening the discussion on Professor Butterfield's paper, said that there was a great need to distinguish between the two words "demand" and "need" in relation to the Health Services. The medical profession and others were increasing their demands for technical services, such as renal dialysis. At the same time there was an increased need for such services because, for example, patients with hypertension were surviving longer and exhibiting renal failure instead of dying from acute hypertensive failure. It was too easy to equate "demand" and "need". What had to be considered was what medical services or what medicine was really needed by the community and what should be done to satisfy these needs.

It was not true to say that all who required medical services—i.e. "needed" them—in fact obtained them. In the past most disease had been acute and thus demand had been immediately overt. Nowadays it was very difficult to recognise when an individual really required to be treated. Most diseases which caused impairment and disability developed gradually; they only became evident after a period of time when usually no cure was possible. Thus demand was often occult and need often unrecognised. For example, with bronchitis the first stage was the smoker's cough. Very few patients or individuals with this manifestation of the condition recognised that possibly they needed medical services.

This led on to the problem of prevention of disease. With the acute diseases, prevention had been largely a community action. Outbreaks of diarrhoea could be prevented by improving the water supply. Most acute diseases were caused by one organism with perhaps one or two contributing factors, such as a bad water supply. The chronic diseases, however, generally involved a variety of different causal agents. No single agent was responsible for conditions such as coronary arterial disease, diabetes or cancer of the lung. No amount of community action would help in preventing such conditions; it was largely an individual action.

It was necessary to discover both the individual at most risk from the particular agents known to cause the diseases and to distinguish the individual who had the first stages. For example, the cigarette was probably the major

single health hazard in 1968; but no amount of community action would prevent the individual from smoking. It was essential to find out how to distinguish the individual at greatest risk from smoking the cigarette, how to persuade him to stop smoking, and how to help him to do this. Similarly, individual action was required regarding diet and activity, two factors commonly implicated in diseases currently common. Efforts to persuade individuals to take individual action had failed miserably and epidemiological findings were not yet good at picking up individuals at greatest risk.

A major problem was that of research into the education required for individuals—who should be educated to take individual action which would prevent the development of demand and what the message to them should be.

* * * *

In the general discussion the need was stressed for hospitals to be responsive to the needs of the community. The specialist working in a highly equipped hospital and the general practitioner who sees patients in their own homes must be made to feel that they were both working to the same end. It is in the health centre that the new techniques of diagnosis and treatment can be focussed on the individual patient. The number of over 65s was increasing greatly. This was the group that was subject to chronic illness requiring long term continuing care. The hospital was not a suitable place for such care; it had to be given in the community. In place of a singlehanded general practitioner what was required was a group of general practitioners working with a team of helpers, professional, social and administrative. In the future a health centre should be "the laboratory of the community"; the hospital with its variety of specialists should be its tool. In addition the health centre must play an increasing role in medical teaching, demonstrating in particular how to meet changing medical needs.

It was also pointed out that health was not simply absence of identifiable disease. There was a need to identify people who, for various reasons, could not cope with life. These people were "ill" in a much broader sense. They may or may not take their problems to their general practitioners. But general practitioners could only help these people effectively if our society were modified and if the variety of workers in this field came together, each group applying its special skills.

The need for co-operation within the hospital service was stressed by other speakers. New developments meant new demands for nurses and technicians and it was essential for those who planned new developments to appreciate the need for advance planning of staff requirements. Trained nurses could not be produced at a moment's notice. It was also pointed out that technicians were controlling apparatus which was increasing in complexity and that their responsibilities were outpacing their salaries.

One member stressed the need for randomised control trials to show the relative costs of treating patients as in-patients and out-patients as well as the most effective methods of treatment. The economists should work out cost benefit analyses in this field. The medical profession needed to be much more positive in assessing what they were doing and what they ought to do. Hostel-type beds and pre-discharge wards were of value as their provision could result in fewer acute beds and consequently prevent the misuse of hospital facilities and nurses' time.

Concern was also expressed that pressure to satisfy new medical demands might, with the limited resources available, lead to neglect of the more con-

ventional needs. For example, if a hospital opened a renal unit to keep 50 patients alive a year they would spend a sum which could have been used to rebuild an operating theatre. While there were other factors which had to be considered, the question of costs must not be forgotten.

Another scarce resource was doctors' time. The Nuffield Hospitals Trust had estimated an average out-patient consultation time as about 7 minutes. The system would break down if the time were materially longer. Yet a longer time—up to 15 minutes—had been recorded in a private practice in a particular speciality. If it were assumed that there was a patient demand from 4 to 5 minutes of uninterrupted consultation time, it was impossible to make such a provision on a national scale. One of the things which could not, therefore, be provided for all was a long consultation time on demand.

Some members referred to the activity of local authorities in adjusting their care arrangements to take account of the large number of people suffering from mental disorder. If what Professor Butterfield had said about the incidence of symptomless physical disease were true perhaps local authorities should be planning regional clinics. More emphasis on preventive medicine was required in its application to the individual. There had been partial success in some areas, but dismal failure in others. In some boroughs, immunisation was only at the 50% acceptance rate; there were more deaths than ever as a result of smoking; cervical cancer still resulted in too many deaths; there were diet deficiencies; and amongst old people there was a very great need for chiropody due in no small part to the fact that good shoes had not been available and that feet had begun to be deformed at an early age. More positive health education was needed. Radio and television should be used to inform people how to stay healthy, live healthily and live longer.

* * * *

Professor Butterfield replied to the discussion and said that he agreed there was a need for research programmes on ways of detecting the person at risk.

Before long doctors would be able to see a health centre related to a medical school at Thamesmead where medical students would have a chance to see some of the exciting things that can happen there. The point made about the demand for doctors' time was very cogent. He found that if he wanted to be kind to his patients, he went without lunch. It was possible, however, that reorganisation could help doctors. Even so, more doctors were needed, as the Royal Commission on Medical Education had pointed out.

The problem of people who could not cope with life was the problem of the moment. The starting point had to be some philosophical discussions and publications about societies based on aptitudes rather than economics or theories of growth rate. He had been shocked when told that it was quite likely in some quarters that 15% of people might be unemployable by the turn of the century. A Californian had told him that in California it would be an honour to have a job in 50 years time because the computer would be doing the work. This was an important developing problem.

Professor Butterfield agreed with what had been said about nurses and staffing problems. Doctors were so busy that they did not talk to matrons and nurses enough. He also agreed that the opportunities for re-opening health education through the mass media were enormous and he hoped that now the chairman of the B.B.C. was a doctor and a distinguished health educator something would be done about this.

Efforts were being made to get the economists interested in the question of costs. Control trials were essential to establish the factual foundations on which to make priority decisions.

It was true that more and more technicians were needed. The natural science schools in the new universities had not got a proper career structure for their graduates. This was part of the student unrest on the art side—people being unable to see what contribution they could make. If young zoologists, botanists, biologists and pharmacologists could be shown what they could do to help the doctor, the demand could be satisfied. At present one doctor had 13 supporters in the Health Service and the rate would probably go up to 14 or 15.

Professor Butterfield accepted that hostel beds were needed. In Leiden the out-patient clinic had hostel beds overhead and at Guy's more than 20% of patients could be put into hostel beds.

An enormous proportion of Health Service money was being spent on mental symptoms. Local authorities' costs had gone up from £1.2 million in 1949 to £20 million in 1966 in this zone; it was probably going to go up still further. With a lot of the symptoms, doctors were inclined to say that patients were psycho-neurotic, but a large-scale automatic laboratory might help in finding possible explanations for so called psycho-neurotic diseases and treating them might help to improve the quality of the care being offered.

Session 2 Evolving Practice

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To be asked to prepare this paper was an honour but, in addition, the event which we are commemorating has a particular personal significance, because, at the time that Aneurin Bevan was presenting the National Health Service Bill to the country, I was one of those involved, through the British Medical Students' Association, in putting forward the views of students on that proposed radical reorganisation of medical care. My membership of the medical profession dates from the year before the introduction of the National Health Service, and it is therefore singularly satisfying to have been given the opportunity of trying to take stock of at least some of the many developments which have taken place since 1948. It is also, I hope, permissible to attempt to predict the future implications of certain of the more recent trends.

As a medical student in pre-National Health Service days, I had relatively simple impressions of what were to become the three administrative components of the Service. The hospital was the embodiment of all that was best in medical care and my own teaching hospital was, naturally, the centre of the medical universe. General practice was a place for rugged individualists who tackled everything from advanced midwifery to various forms of surgery and whose personalities were at least as powerful as their potions. The Public Health Service, leaving aside its hospital function, I associated largely with the less salubrious aspects of the crude physical environment. These three branches of my profession seemed to me to be quite separate and to have a very definite pecking order and, in retrospect, their practitioners might well have been represented by the archetypes of Kildare, Cameron and, of course, my dear old friend and colleague Snoddie. Perhaps I might add that, had any of my fellow students suggested that I was fated to become a medical administrator, I would have expressed impolite incredulity.

As a matter of convenience, I propose to look serially at the three administrative components of the National Health Service in the light of the changes which have occurred since 1948, and to refer to some of the trends which have emerged or are in the process of emerging. In doing so, I recognise that to divide my subject up in this way is illogical because the most significant development of all has been the steady movement, particularly in the last few years, towards functional, if not administrative, unification of the National Health Service.

Hospitals

The hospitals represent the largest single investment of the Service in terms of capital and revenue expenditure and of skilled resources, in addition to which they are coming to constitute the physical and spiritual centres for all Health Service workers in their areas. On the other hand, no doubt partly on account of their monastic origins, hospitals have tended to be inward-looking and to be inadequately aware both of the communities which they exist to serve and of the roles of doctors and other Health Service personnel who practise predominantly in these communities. One of the most interesting recent trends has been an awakening of interest on the part of hospitals in those wider aspects of medical care, and it is particularly encouraging to find that this movement has begun

to spread to some of the London teaching hospitals, the work of Professor John Butterfield's team at Guy's being an outstanding example. This new movement within the hospital service will inevitably lead to its playing a more effective and less episodic part in the provision of medical care, and to its developing a much greater interest in such subjects as epidemiology, health education and the prevention of disease which, erroneously, have not hitherto been regarded as having any relevance to the functions of hospitals.

The main concentration of advanced technical skills will continue to be based on hospitals, but their true role will increasingly be to care for those who really need their specialised staff and facilities, either for diagnostic or for therapeutic purposes. There has been a general levelling up of standards throughout the hospital service since the advent of the National Health Service and, in England and Wales, the distinction between teaching and so-called non-teaching hospitals is at last becoming less rigid—a process which, as one would expect, is considerably more advanced in Scotland. These changes have been accompanied by the emergence of the concept of the district general hospital, with its ability to provide the major types of care for its surrounding community, leaving the rarer specialties to be supplied at sub-regional or regional levels.

The growth of specialisation is inevitable, and this leads on to the need for larger units, a development which is by no means confined to Health Services, having its analogies in industry and, indeed, throughout the whole of our national life. This concentration of resources brings clear advantages in terms of availability of expertise, but simultaneously poses problems of communication and of management. Neither is insuperable, and each constitutes a challenge to everyone who works in the hospital service. Thus, largeness need not and must not imply an impersonal service to the sick; and good management should be recognised as directly relevant to the effective care of patients. These matters are the object of considerable discussion, and this has been stimulated and sustained by the publication of such documents as the first report of the Joint Working Party on the Organisation of Medical Work in Hospitals.¹ Those of my hospital friends who are familiar with the cover design of this report, and hence with its pseudonym, may understand the slip of the tongue I made the other day when I referred to it as the product of a committee presided over by "Sir George Cogwheel".

Within hospitals, the rigid allocation of beds to consultants, with the constant danger of their becoming status symbols corresponding to, but more dangerous than, the size of the general practitioner's car or the depth of pile of the medical officer of health's carpet, is giving way to the more relevant classification of the type and degree of care which each patient requires. The traditional attitude towards beds was epitomised in a letter from a teaching hospital, which assured a committee of which I am a member that all patients of a certain type "are cared for in the Professor's beds"; whereas the emerging new attitude was expressed by Professor Butterfield in his recent Rock Carling lecture when he said, albeit perhaps a little ambiguously, that he wanted to see "more sharing of beds" in hospitals.

The medical and social advances which have taken place since 1948 have brought about changes in the pattern of hospital admissions. Thus, the efficacy of immunisation and other preventive measures has led to an enormous re-

¹ H.M.S.O., 1967.

duction in the need for hospital beds for such diseases as tuberculosis and poliomyelitis, whilst the advent of more effective therapeutic agents, such as antibiotics, has enabled general practitioners, increasingly in association with other members of the community health team, to treat large numbers of patients in their own homes. Improved housing and social services have similarly facilitated the development of home care.

In addition, successful attempts have been made in several areas to rationalise the division of care between hospital and home and to adopt more flexible attitudes towards such matters as the length of time a woman should stay in hospital after confinement; or a man after the repair of a hernia. The retention of patients in hospital for fixed periods after operation for no better reason than tradition is coming increasingly to be questioned, and experience has shown the wide scope for policies of planned early discharge and, in properly selected cases, for out-patient surgery. Furthermore, the provision of simple hostel accommodation in association with general hospitals, adumbrated in the report of the Chief Medical Officer of the Ministry as long ago as the year of the inception of the National Health Service, is likely to be a growing trend for those who do not require the full panoply of care in a ward; as is the use of day hospitals for patients who can suitably return to their own homes at night. In a similar vein, the admission of patients to hospital for investigations which could perfectly adequately be performed as out-patients is diminishing.

These developments are leading to a rapidly expanding interest in the overall pattern of provision of medical care and to the realisation that there is a reciprocal relationship between the services supplied by hospitals on the one hand, and by general practitioners and local health authorities on the other, this reciprocity being equally applicable to prevention and to treatment. It is this relationship which makes it at best unrealistic and at worst utterly jejune to try to plan the development of the three administrative branches of the National Health Service in isolation from each other.

I welcome the growing interest in the place of the community in medical care, and believe that the merits of this must be assessed solely in terms of what is right for the patient and not on the basis of sterile arguments about former practices or about the particular pocket from which the requisite money will need to be forthcoming. Ultimately, the question resolves itself into what form of care is best, physically, psychologically and socially, for the individual patient, and there is need for much more experimentation, accompanied by attempts to measure the outcome of different approaches. There is also wide scope for investigations into the relative advantages of various forms of hospital and domiciliary care both in terms of costs and of the deployment of limited resources of skilled manpower and, in some cases, of expensive equipment. For example, it is commonly assumed that domiciliary care is invariably much less expensive than treatment in hospital, but it is important to ensure that this difference in costs is not, in part, due to a comparison between an indifferent level of care in the former and a higher standard in the latter. Similarly, there is need for more study of the deployment of midwives and of state registered nurses between the hospital and domiciliary services. If I might expand one aspect of that last point, the local authority nursing services have, in relation to their total numbers, a substantially higher proportion of state registered nurses than the hospitals, whereas the skills which, at the moment, district nurses are commonly required to display tend to be less than those required in hospital. This represents a sad imbalance in our present manpower situation.

General practice

In considering the area of overlap between hospital and domiciliary care, it must be remembered that the great bulk of illness is, in fact, treated by general practitioners and that this country remains as firmly committed to them as doctors of first contact as it was when the National Health Service was inaugurated. On the other hand, since 1948 there have been several significant developments in relation to general practice, including the foundation of the Royal College of General Practitioners, the publication of the Gillie Report and, more recently, a distinct trend towards reorganisation and towards a revised definition of the role of the family doctor. Dr. John Brotherston's cottage industry is, in fact, currently in the throes of its own industrial revolution.

The reorganisation is directed towards making general practitioners less isolated both from each other and from what hitherto have been regarded as quite separate parts of the Health Service structure. This has involved a movement away from single-handed practice towards working together in groups, and the size of these groups is enlarging and, in the view of the Royal Commission on Medical Education, should enlarge still further, to include 12 or more general practitioners in each. This trend towards bigger units is in many ways analogous to the state of affairs which has already been noted in relation to hospitals and which must also apply, sooner or later, in the field of local government.

Such larger groupings in general practice facilitate the attachment of local authority health visitors, social workers, nurses, midwives and nursing auxiliaries; and attachment schemes, although still applicable to only a small minority of such staff, have already demonstrated the contribution which they can make to effective communication and hence to the usefulness of the community care team. Patients, doctors and attached staff alike benefit from such groupings, and particularly from the greater selectivity of approach and delegation of duties which attachments facilitate. Thus, the pooling of knowledge within the team enables priorities to be more adequately selected and a gradual reassessment of roles to take place. The health visitor is helped to extend her work to cover a wider range of clients and duties; the nurse ceases to be under-utilised and has more interesting and responsible tasks delegated to her; and the general practitioner can take his rightful place as the leader of a co-ordinated team, instead of remaining an isolated entrepreneur in the realm of do-it-yourself. It has also interested me to hear spontaneous remarks from patients about their appreciation of receiving care from a team rather than from a collection of disparate individuals.

Whether the community care team should be based on group practice premises or on a health centre is, in many ways, immaterial, as it is the attitude of mind of those working together which matters rather than the ownership of the bricks and mortar from which they work. Nevertheless, the upsurge of interest in health centres has been one of the most remarkable features of the past three years, and there is no doubt that a well-designed centre can contribute much towards practice efficiency and towards ensuring closer co-operation amongst all who work in it. Incidentally, when I say a well-designed centre I mean, amongst other things, one which does not have three separate wings for the three administrative branches of the National Health Service.

Although, as has already been said, this country is still firmly committed to the general practitioner as the doctor of first contact, there are differing opinions about his precise future role. At one end of the scale, many believe that he should remain a generalist, whilst at the other, systems have been advocated whereby

such doctors would restrict themselves to dealing with specific age groups or with particular types of disease. Between these two extremes there seems to be emerging an intermediate arrangement under which doctors in group practice can have the opportunity of developing special clinical interests. Thus, each member of the practice would continue to have his own list of patients towards whom he would act as the doctor of first contact but, in certain instances, he might ask one of his fellow practitioners for help and advice. This sort of arrangement might be applied, for example, to the control of diabetes because, if one member of a group practice had a particular interest in that disease and assisted his colleagues in the work of caring for the diabetics in the practice, he would see sufficient numbers to become more confident in such work than would be the case if he saw only those diabetics who were on his own list of patients.

Such special interests are also helpful in relation to another growing point in general practice, which is the establishment of closer links with hospital medicine. There has been a steady movement during the past 20 years towards giving general practitioners access to hospital pathological, X-ray and other diagnostic facilities and this is a primary necessity if these doctors are to be enabled to carry out their work effectively and to derive adequate satisfaction from it. In addition, it has become clear that many general practitioners would like to play a more positive part in the hospital, either by undertaking the continuing care of patients whom they have admitted or by having direct responsibility as members of the staff of appropriate clinical divisions. Thus the family doctor with a special interest in diabetes could usefully be fitted into the hospital medical division; and, similarly, one with an interest in psychiatry should be able to develop and use his skills for the benefit of hospital patients. Other examples of potential special interests are to be found in the fields of industrial or child health, and in the case of the latter, the report of the Sheldon Committee has pointed the way for suitably prepared general practitioners to assume responsibility for much of the clinical work at present carried out by public health doctors. I think the great majority of my colleagues in the public health service welcome this; and if that is not altruism, what is?

In general practice, there is wide scope for exploring new approaches to the provision of medical care, and this process will no doubt be stimulated by improved vocational training and by closer contact with other branches of medicine. It is clear that there is ample room for the general practitioner to delegate certain aspects of his work to other members of the health team, and this process may well extend beyond the carrying out of defined tasks on the specific instructions of the doctor, into the realm of limited diagnosis. Such developments should be both encouraged and evaluated as contributions towards enabling the general practitioner to assume his emerging new and wider role in the National Health Service of the future.

Public health

The local health authorities, which constitute the third branch of the National Health Service, have also been involved in profound changes during the past 20 years. Unfortunately, whereas the regional structure of the hospital service is essentially a rational one, this is not true of the local health authorities, which vary enormously in size and resources, and partly as a result of this, the standards of care which they provide are more variable than those applicable in the hospital service. Nevertheless, a substantial degree of levelling up has taken place within the local authority service, particularly since the introduction of long-

term planning in 1962. Local authorities also have distinct advantages over the other two segments of the National Health Service as a result of their flexibility both in planning and in finance and, whilst this flexibility can on occasion result in lack of progress, I believe that the majority of authorities have been ready and willing to experiment and to adapt their services to changing social and medical needs.

Many public health activities had their origins in stop-gap measures designed to overcome deficiencies in former patterns of medical care, and the most encouraging recent development has been the movement away from the provision of services in isolation from other branches of medicine towards a co-ordinated system, a notable example of this being the attachment of staff to general practices. Similarly, a variety of links have been forged between the public health and hospital services in the fields of staff training and of the care and after-care of patients. In some areas, nurses and midwives undertake regular refresher courses in the wards and departments of their local district general hospitals, and integrated systems of training are likewise helping to build up mutual understanding and trust, thereby paving the way towards agreed policies on discharge and after-care, a process which is further strengthened where hospital staff are enabled to spend periods working in the community.

Health visitors can form useful links between the hospital and the domiciliary health team, thus providing continuity of care for patients. Various joint medical appointments have come into being between hospitals and local authorities, and these are especially valuable in geriatrics, in psychiatry, and in the care of handicapped children and adults. Joint social work schemes, particularly in the realm of psychiatry, have been evolved to the advantage of all concerned, and joint appointments also exist in a large number of other services in which both hospitals and local health authorities have responsibilities.

Quite apart from joint appointments, local health authorities have played a large part in the process of transferring the care of certain groups of patients from hospitals to the community. Progress has been particularly striking in the case of the mentally subnormal, where the emphasis has clearly passed to community care for all but the most severely handicapped, and there has been a more than tenfold increase in the provision of places in training centres during the past 20 years. Although technically outside my brief for this paper, there has also been a substantial increase in the provision made by local authorities for accommodating the elderly and for helping the permanently handicapped.

The closer relationship which has developed between public health staff, general practitioners and hospital personnel is, I hope and believe, also having a beneficial effect by reminding these last two groups that the scope for prevention in relation to modern epidemics such as lung cancer is no less than it was in the past in the case of such infectious diseases as tuberculosis. It is, in theory, unnecessary to have a branch of the medical profession with a particular responsibility towards the prevention of disease, as this should enter more and more into the work of all doctors. In practice, however, it is still necessary, as otherwise the claims made on resources by prevention, with its essentially long-term results, would stand in danger of being totally submerged by the competing demands of therapy, with all its more immediate glamour.

The oft-repeated statement that prevention is better than cure is in danger of becoming a meaningless cliché, as those who employ the phrase usually mean simply that they would prefer to remain healthy but are unwilling to take any positive steps to attain that goal. It is for this reason that health education, in

the wildest sense of the term, has come to be regarded as the most important activity of the public health service and one which must also come to be applied in an organised way in general practice and in hospitals. It already exists in these services, but I do not think it could be said to do so in an organised way. There are enormous anti-health interests at work in our society, and the need for leadership and for a skilled approach to health education has been recognised by the number of local health authorities which have set up specialist health education sections, and by the recent establishment at national level of the Health Education Council. Priorities will always exist in medicine, and health education must be put before many other more dramatic, more publicised, but less relevant activities.

Health education also enters into any consideration of the early detection of disease, both where this involves encouraging those who think that they might be suffering from some particular condition to go to their doctors for diagnosis, and in carrying out specific screening tests in selected groups of the population. This work of screening is still in its infancy, often posing more problems than it solves, and it is clear that much remains to be learned, even about such basic matters as the dividing line between normality and abnormality. Nevertheless, where selective screening is deemed to be appropriate, local health authorities have a part to play in educating the public, and possibly in providing the administrative mechanism for screening, but co-operation with general practitioners and the hospital service is essential in view of the substantial load which any screening programme is likely to place upon them.

It is also vital to ensure that screening never becomes an isolated procedure or an end in itself and that all patients thought to be suffering from some abnormality which calls for and is amenable to therapy are, in fact, effectively treated and followed up. This last point may seem to be pathetically self-evident, yet there is a real danger that, as a result of deficiencies in medical education, reinforced by the tripartite structure of the National Health Service, the processes of prevention, screening, diagnosis, treatment and after-care will become fragmented amongst a variety of doctors and other health workers who, although enthusiastic about their individual responsibilities, nevertheless fail to appreciate where these fit into the over-all pattern of medical care. In consequence, they will have an inadequate understanding of the ultimate clinical, social and administrative consequences of their own actions.

Conclusions

In looking at the problems which lie ahead, it is going to be necessary to establish new criteria for measuring health, as well as for gauging the effectiveness of various aspects of medical care. Many traditional yardsticks, such as the infant mortality rate, which has been halved since 1948, have no more than limited value for the future, and more attention should be paid to such matters as the steady and unnecessary increase in deaths from lung cancer, which have more than doubled during the same period; and to the unsatisfactory life expectancy of middle-aged men.

There is need to exploit Britain's advantageous position in relation to vital statistics, epidemiology and record linkage, and there is wide scope for continuing operational research in all branches of the National Health Service. This must be accompanied by experimentation in the provision of services, and whilst this can be carried out virtually anywhere, particular opportunities present themselves in the current generation of new towns and cities being planned and

built throughout the country. These opportunities have been seized with enthusiasm, and whereas in the past many of us had to be content with medical castles in the air, we have now progressed to the stage where, at the drop of a hat, we will produce our architects' drawings for these very castles.

The aphorism that the whole is greater than the sum of its parts is particularly true of medical care, and at the end of the first 20 years of the National Health Service it has come to be realised that to attempt to divide care into arbitrary components such as hospital and community, or prevention and cure, is a futile exercise. The pattern of need for hospital services will depend both upon the degree of success in preventing disease from arising and upon the standard of community care provided by general practitioners and local health authority staff. Similarly, prevention merges into cure when viewed in terms of such screening procedures as cervical cytology.

For these reasons it has been most encouraging to observe the gradual removal of the artificial barriers which have for too long separated the three main branches of medical practice. Much remains to be done, and the National Health Service will no doubt be profoundly influenced by the Report of the Royal Commission on Medical Education and by the forthcoming reports from the Seebohm Committee and from the Royal Commission on Local Government, in addition to which, of course, the Minister's green paper is awaited with particular interest. Waiting for the publication of reports has, indeed, replaced golf and sitting on committees as the favourite sport of the medical profession. Nevertheless, even without legislative or administrative change, the National Health Service has been moving steadily towards functional unity, as has been demonstrated by the recent Health Services and Public Health Bill, certain sections of which will legitimise various ventures in which some of my colleagues and I have indulged for years. Thus the provision of a joint hospital and community midwifery service will become legal and my only fear, as a Calvinistic Scot, is that the removal of the sweet savour of sin may henceforth make such matters less enjoyable than they have hitherto been.

There are, of course, still obstacles to co-operation in the form of individuals. There is the consultant whose ivory tower has frosted glass windows and who has no realisation of the big world which exists beyond his microcosm; the general practitioner whose personal insecurity renders him incapable of joining with other members of the health team; and the medical officer of health who broods over the halcyon days which exist only in his imagination instead of getting on with the task of reorientating his department to deal with present-day needs. These, however, are the minority, and the great majority of the medical profession and of the many groups who work with it accept the need for a united approach to the provision of health services.

I have not hitherto been one of those who believe, as an article of faith, that the administrative unification of the National Health Service is the sole road to salvation and that it would automatically and by itself ensure a better standard of medical care; nor have I been a vociferous advocate of such reorganisation, because of my fear that over-emphasising its importance might lead to lack of progress within the existing framework of the Service. In the light of changing philosophies in medical education and in the practice of medicine, however, it now seems to me that unification is both desirable and inevitable. Under present arrangements, the over-all pattern of medical care can be seen solely from the upper floors of Alexander Fleming House, as peripherally the boards of governors, regional hospital boards, local executive councils and local health

authorities are responsible for what can only be described as arbitrary fragments of the whole. In the face of the changes which I have endeavoured to outline in this paper, such fragmentation has become increasingly incompatible with our present and future needs, and it is clear that the statutory bodies in future charged with the regional or local administration of the National Health Service should be able to look alike at hospital and community, prevention and cure.

Medical students of my particular generation are now midway between discussion of the National Health Service Bill and retirement. The generality of us supported this Bill, believing it to be an essential step in the evolution of this country's social services. It is easy to criticise the National Health Service, and many aspects of it indeed merit criticism; but it is also all too easy to lose a sense of perspective. It is my submission that, in the years since 1948, we have seen substantial advances in the provision of medical care; and that, in trying at this conference to take stock of the situation, we are doing so not as an exercise in retrospection but rather with the intention of establishing a baseline on which to build for the decades which lie ahead.

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Mr. H. P. Travis, Group Secretary, Bolton and District Hospital Management Committee, opened the discussion on Dr. Reid's paper. He referred first of all to the progress which had been made over the last 20 years in developing the hospital service but pointed out that some undesirable features of the pre-1948 Service could still be seen today. Firstly, standards in both accommodation and attitudes which had been conditioned by the "charity" standards of the pre-1948 Service could still be seen in some National Health Service hospitals of today. This was despite the fact that the Hospital Service had taken the largest share of the amount of money available from the Exchequer. Everybody wanted to see put into practice what Dr. Reid had suggested, and somehow or other the money would have to be found. There was no obvious answer, but only if hospitals received more money would a Health Service be achieved of which all could be proud.

Secondly, there was still an obvious difference between the teaching hospitals and the peripheral hospitals. The former had a proud and independent attitude; they still selected their patients. They had not, as yet, been integrated into the major problem of the care of the community. In the peripheral hospitals it was common for a consultant to see perhaps 60 patients in a session with the assistance of one junior doctor from overseas. Overburdened general practitioners sent patients to hospital when they did not require hospital treatment; and often patients arrived at the Accident and Emergency Department simply because their doctor had sent them there on a previous occasion.

All this involved the question of priorities. Should there be an expansion of the rarer specialist services which are expensive in manpower and money, or should basic problems be dealt with first? Unless the Hospital Service received a larger share of the national income, it could not do both.

Another basic problem was the number of doctors. To have more doctors meant having more medical schools, and that again required more money. Very many more aids were needed to allow them to do their job of doctoring properly. And if there were to be proper post-graduate education with doctors being sent away on study courses, etc. more trained people would be needed in order to keep the day to day service going.

Behind all this was the question of morale. This had to be maintained especially at the point of contact with the patient, whether that point was in general practice, in the hospitals, or in the community services. Only if morale were maintained by all devices of human relations and communications could the service keep on the right road and continue to improve as it has done since 1948. A magnificent advance had already been made by the improvement of contacts between hospitals, local health authorities and general practitioners. This could be seen particularly with the geriatric, maternity and mental health services. Regular meetings to discuss problems and to allocate patients to the right places for treatment and to see that the right resources were being employed offered, possibly, the only solution for the future. Outside the hospital service it was encouraging to hear of the progress being made in the setting up of group practices and health centres but the new arrangements would need to be adequately staffed. For example, if health centres were set up with the idea of relieving hospitals of work, would already overburdened general practitioners be able to give adequate service there? Perhaps there was a case for considering health centres built in the grounds of general hospitals. These might help to solve the problem of the Accident and Emergency Departments and allow implementation of the Platt Report recommendation regarding the treatment of the "casualty" type of patient.

Increasing integration of the various branches of the National Health Service meant that it was necessary to look at certain aspects of staffing. For example, nurse training might be made more comprehensive if it included more weighting towards the community services, both general practitioner and local authority. Hospital nurses should go out into the community services more often and at an earlier stage in their training. Such a development would help to lead to a greater understanding in the ward of the problems of the patients and their families. Those responsible in hospitals, local health authorities, and general practice should set the leadership in this field. Integration of the three branches of the Service was a matter of human relationships and communications. Morale and liaison could not be enforced. The Service should not look for the solutions to problems in the introduction of administrative changes which might possibly delay progress, but in a willingness to make the present administrative arrangements work well.

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Further reference to health centres was made in the continued discussion. Proposals for revision of the administrative arrangements for the National Health Service had still to be studied, but even without integration of administrative arrangements there could be, in health centres, integration of the functions of health and social workers in the interests of the individual patient and of the community. General medical practitioners were able to provide a much higher standard of service because appropriate aspects of their work could be undertaken by secretaries and public health nursing staff. Much of the clinical public health work of local authority doctors could be undertaken by general medical practitioners, home nurses, health visitors and midwives based on health centres. Medical social workers and psychiatric social workers could also be based on these centres. General dental practitioners, ophthalmic practitioners and pharmacists might also become increasingly interested in working at these places. Bearing in mind the need to provide facilities for a limited number of visiting hospital specialists, future health centres might be

quite large and costly buildings. This would involve capital outlay and increasing competition with other local authority departments for scarce capital resources. Rapid development of centres was unlikely, but should be encouraged. The centres would also enable the keeping of better morbidity records, the intensification of health education efforts and the development of programmes of screening tests.

One speaker drew attention to the need for looking after the whole care of the whole patient. "Care" meant something more than treatment. Total care implied comprehensive investigation, treatment, and management (for want of a better word) of the patient. This meant making the maximum use of all services—local health authority, social and welfare services, general practitioner services and that part of the hospital service which was needed in order to make comprehensive care complete. For the majority of cases for whom general practitioners were responsible the hospital was required for its out-patient department, for its open access to laboratories and X-ray department, and for its domiciliary visits by specialists to the patients' houses, and, if possible, to the general practitioners' surgery. The problem was not necessarily one of a shortage of doctors and beds. Shortage might exist but so did misuse. Within the next few years there ought to be an assessment of the total needs of the country by areas to see the extent to which a misuse of beds and doctors had been allowed; and to see whether the comprehensive care of patients could be more economically carried out if doctors worked together as one unit, hospitals providing the specialists needed to look after special patients, with the other two branches of the Service playing their proper share in looking after the rest.

Health education was discussed further and reference made to the setting up of the Health Education Council. One member welcomed the Council's establishment but stressed that there was an enormous job to be done and it was difficult to believe that the Council would ever have sufficient funds. Television was a really effective medium for education and a small, active advisory body should be set up to work in conjunction with the B.B.C. and I.T.A.

Reference was made by one speaker to the lag between evolving patterns in psychiatric practice, with today's emphasis on community care, and the restriction of the psychiatric nursing service to the hospital field. This discrepancy between theory and practice was damaging to the patient and limited the effectiveness of the psychiatrically trained nurse. Psychiatric patients were treated in hospital and prepared for an early return home, but for want of skilled supervision return to hospital often followed, sometimes in distressing circumstances. Any attempt by the hospital psychiatric nurse officially to pursue the interest of a patient into the community could be unwelcome to local authority staff, but at the same time a wide range of well-intentioned, but not always well qualified, people were permitted to extend an authority over the patients. The result was frustrating to the nurse, wasteful of his special skills and against the interests of the patient. A comprehensive authority was required to direct and protect the interests of the patient for as long as he might require psychiatric supervision; to secure this a community service of trained psychiatric nurses had to be established.

Another point of view about nursing services was put forward. Wastage of nursing personnel was important and far more trained nurses should be in hospital where acute work had to be done and where people really needed nursing. On the district, trained nurses could be replaced by enrolled nurses and auxiliaries working under supervision.

Another speaker made a plea for experiments in the Health Service. There were continuing theoretical discourses about the optimal organisation of the Service, but no deliberate attempt by experimentation in different areas to see whether different structures, such as area health boards, would work and work well. The object was to match the patient's requirements to the facilities that were available. This would mean breaking down the present division between institutional work and domiciliary work.

The importance of good communications was also mentioned. It was important that general practitioners should give full information about patients admitted to hospital; in return they should have full and timely information about discharged patients. At present, difficulties were sometimes geographical and these might be overcome if a large health centre were built on the same site as the district general hospital. There could then be provision for hotel-type accommodation for patients coming for investigation. It was a retrograde step to build health centres of small size and away from district general hospitals.

The need for consultants to stop regarding their beds as a territorial freehold and as a status symbol was urged by one speaker. It should be possible for all beds to be used to meet demands; it would then become easier to increase the number of day beds in hospitals. Day beds should be provided in health centres also. The result of all this would be a spectrum of care where the distinction between general practitioners and other sorts of practitioner was no longer valid. It had to be accepted, too, that Government finance was going to be limited but this did not mean that alternative sources of funds should not be considered.

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Dr. Reid replied to the discussion and referred first of all to the question of the need for more money. It was necessary to look at the total money available and to the total service. Decisions could not be taken by looking at needs from, say, the hospital point of view alone. The available money had to be spent in whatever way was best for medical care as a whole. This must also be the approach to the subject of morale. The first need was to let everyone working in the Health Service understand more about how he or she fitted into the overall pattern. There was a need also to do a lot more in informing the public about the entire National Health Service. Those in the Service tended to assume that the public understood existing frustrations; they also assumed that the public understood the structure of the Service. Generally people were eminently reasonable and did not make unreasonable demands unless they failed to understand. One of the jobs of health education was going to be to help people to understand what medical care was about; this meant that those working in the Service had to have a clear picture themselves.

Mention had been made of social workers and in this connection the Seeborn Report was eagerly awaited. There were sufficient medical and social problems in this country to keep every person of goodwill in both the medical and social work professions fully occupied. He hoped that whatever developed as the physical unit closest to those requiring help would contain every type of worker—doctors, nurses, social workers, etc.—and that there would be no demarcation disputes.

The setting up of the Health Education Council was a step forward but the main effort in health education must be peripheral and continuous. Nowadays everyone seemed to accept that this was so. Television could certainly be used; there had already been some useful programmes.

Dr. Reid said that he was sure that the psychiatric nurse had a role in the community. He could link up with both the district nurses and the social workers. In this field local authorities had ample scope to use their own initiative until such time as a better administrative arrangement made formal provision for a united approach to care.

Finally, it was important that workers in the Health Service should not lose their self-respect. When the services of 1968 were compared with those of 1948 it was clear that enormous progress had, in fact, been made and that, whilst much remained to be done, there was every reason for being proud of achievements. We must not undersell ourselves.

Session 3, Part I Resource Planning

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My subject is "resource planning" and to me, who am not a trained economist and who must use simple terms, resources appear to consist primarily of money and manpower and secondarily of the accommodation, equipment and services which these two basic resources can make available, either separately or in combination.

Both these resources are limited and will continue to be so; whereas the demand for medical care is the very reverse and is virtually unlimited. Professor Butterfield dealt with the expansion and explosion in demand. We are faced along with the rest of the world with a situation in which we can do more things in terms of medical and nursing care for more people than our resources can possibly sustain. I think this is one home truth that I should like to emphasise.

In these circumstances, a decision to develop a service in a particular way could result in the using up of so much of the available resources that some other necessary service could not be provided. This is an unacceptable position for the National Health Service, in which it is axiomatic that a service must be provided if it has been clearly identified as necessary and has been differentiated from other types of service which may be useful or convenient but are not fully necessary. These are the hard facts.

The use which we make of our resources and the way in which we deploy them is thus of vital importance both to the individual and to the nation. In our field of service the word "vital" is particularly appropriate for ultimately we are concerned with matters of life and death.

How do I see the pre-requisites for resource planning?

Starting from a knowledge of the existing arrangements and of the resources which currently support them we can proceed to consider what our real needs will be in the future and how we should best deploy our future resources to meet them. A simple logical process as so described, but a complicated and difficult process in practice for it involves some very difficult decisions as to the nature and extent of real need, the careful assessment of the medical and economic effectiveness of different ways of meeting real need, and an acceptance that in many instances the ways in which we have been accustomed to provide a service in the past may not be appropriate in the future.

Before we can get down to resource planning therefore and can take our vital decisions we must have:

- (a) A clear idea of our objectives and the general policies within which it is acceptable to pursue them.
- (b) Information on the extent of need or demand (and I shall examine the difference between these in a moment), and the degree to which these must be met if our objectives and broad aims are to be achieved.
- (c) Information on the nature and disposition of the existing services.
- (d) Information on the use made of existing services and some assessment of the degree to which they have in fact been successful in dealing with the needs or demands.
- (e) Information on the existing level of resources and on the level which is expected to be available in the future.

These pre-requisites are quite obvious but pose certain difficulties and before discussing the process of resource planning itself I would like to go further into these, noting in passing that 4 out of my 5 requirements start with the word "Information". I think this is important and echoes a point which was made by earlier speakers.

Objectives

To begin with let us consider the objectives which it is hoped to attain.

These are set out quite clearly for us in Part I of the National Health Service Act of 1946 which laid on the Minister the duty "to promote the establishment . . . of a comprehensive health service designed to secure improvement in the physical and mental health of the people . . . and the prevention, diagnosis and treatment of illness". This is clearly the main objective of our service. Part II of the Act further defined the Minister's duty in relation to hospital and specialist services as the provision of accommodation and services "to such extent as he considers necessary to meet all reasonable requirements". From the outset therefore—and it could hardly have been otherwise—stress was laid on the importance of the improved health of the community as a whole and it was envisaged that this would be attained through services which would meet all reasonable needs—for no Health Service could possibly set itself the task of meeting *all* needs. It is readily acceptable that needs must be assessed on the basis of medical necessity but it is less frequently appreciated, particularly by enthusiasts dedicated to a specific aspect of medical care, that medical "necessities" are not always absolute and that even when a need clearly exists there may be nothing mandatory about the way in which the service required to meet it should be provided.

Our broad objectives are clear. But what about need and demand, because without an assessment of them we cannot proceed. We have already had quite a few comments on need and demand. Dr. Reid made the point that we need new criteria for measurement. I have already stressed the need for assessment. Professor Holland said it was necessary to detect the people at risk; he dwelt upon the problem facing professional men of trying to decide where need exists in a professional sense. Professor Cochrane raised the question from the point of view of the epidemiologist stressing the need for evidence, and the value of control trials. He therefore dealt with the mechanics of estimating need.

Mr. Freeman talked in terms of meeting demand; he did not talk so much in terms of meeting need. I disagree with him here because I think that the conditions in which we have to operate the Health Service are such that in the first place we can only set ourselves the target of providing services to meet things which we decide are real needs.

Clearly we are going to have to try to define the difference between need and demand and I shall attempt this in a moment.

In the Health field, although we have data which enable us to obtain some idea of the level of demand for the various types of services which are provided it is notoriously difficult to assess need. Even our data for the assessment of demand are inadequate and in any case this is constantly changing. For instance, there is evidence to show that the provision of improved and expanded services in hospital for a speciality in which for some time there has been a long waiting list for out-patient appointments may not in the end result in the intended reduction of this list. An initial fall in the waiting list is followed by a slow return to the original level as general practitioners make increased use of the

service by referring to it patients who would not have been sent to hospital before expansion of the Service took place. Presumably this is because it was not considered worthwhile to refer patients in circumstances in which a long period must elapse before attendance at a clinic became possible. Word soon gets round that a patient who has been attending his general practitioner for years, complaining of backache perhaps, and who has received reassurance, a placebo or palliative treatment is now attending the hospital. The general practitioner in his turn is soon being pressed to refer other patients with backache and the demand for a second opinion is not easy to refuse even if the grounds on which it is made appear to be baseless. Within a year or so not only has the waiting list returned to the level at which it first started but it has frequently exceeded that level in spite of the improved service. However, variation in demand for an established service is only one aspect of the problem. Demands for the provision of quite new services are constantly arising as a result of the application of scientific and technical advances to medicine. We heard about this from Professor Butterfield. In many cases demands develop slowly and the services necessary to meet these demands become gradually established following an initial period during which development is pursued in a few selected locations. Open-heart surgery for the treatment of both congenital and acquired conditions is an example of this sort of process. However, reference to recent events will confirm that in some important instances demands for new services are loudly proclaimed before the value of a new investigational technique is fully assessed or the success of a newly attempted surgical procedure is clearly established.

I want to avoid being accused of being against progress. I should, therefore, point out that there is a clear difference in nature and in acceptability between a demand for the premature establishment of a general service to patients under the National Health Service on one hand, and a demand for the provision of facilities for investigation, development and assessment of a promising innovation on the other. While the former should be resisted, the latter may be accepted in a reasonable number of suitable places in which the necessary expertise exists and the various branches of medicine which are concerned are adequately represented.

The assessment of demand is difficult enough but the assessment of need is harder still. For instance in the example which I have already quoted, was there a "need" to refer that patient and his backache to hospital and was there a "need" for his attendance to be followed by that of more and more other patients for whom no positive demand had appeared to exist before improvement of the Service made possible the attendance of larger numbers. The "need" either for a service or for the treatment of a particular condition in the individual may be bidden by the operation of other factors. It may not easily find expression as a demand. Conversely a demand for a particular service may be either too modest or too excessive in relation to need at any given point in time.

I would like to take a further example from the field of public health. This illustrates our difficulties in relation to need and demand but is also an obvious example of a service which is given on a personal basis to the individual but which gives indirect benefit to others and to the community as a whole. This obvious example is, of course, vaccination against smallpox. The total demand for this service from the individuals who constitute the public at large does not adequately reflect need, certainly in a community sense. The incidence of smallpox in this country is low and to many individuals the threat to personal health

from this disease does not appear to be sufficiently serious to justify acceptance of the minor risk associated with vaccination or to warrant the extra effort involved in asking for protection and the inconvenience of attendance at general practitioner surgery or local health authority clinic to obtain it.

Before an attempt can be made to decide what services are required to meet our objectives and before we can decide how our available resources should be allocated between them we must have as clear an idea as is possible as to what we mean by need and by demand and be in possession of some kind of quantitative guides.

I would like to suggest that in the context of the provision of medical care in the Health Service, "need" should be considered to be the services necessary to deal with the pathological conditions in human beings which, according to present medical knowledge, require action. On the other hand I think that "demand" should be regarded as the services considered to be necessary by the population, whether justified or not—in other words what patients seek and expect. In the definition of "need" the word "action" is important in that it embraces the full range of possibilities and all forms of prevention, treatment, and care in any or all of the branches of the National Health Service.

Decisions that a real need exists—and therefore should be met—require to be taken at both central and local level. At central level existing arrangements for obtaining advice include Standing Advisory Committees with their sub-committees, both statutory and non-statutory, the Department's Advisers and Consultant Advisers and—increasingly in recent years—a variety of *ad hoc* committees and working parties set up for a limited period to give specialised advice on a particular problem. The medical working group on haemodialysis is an example. These advisory groups set up with the approval and co-operation of the professions concerned give invaluable help on a wide range of problems including the determination of real need or otherwise for the establishment of new services and the continuation or modification of existing ones. In one year the Department recently consulted over 100 such bodies. In addition the Department can seek and be offered advice from independent external professional bodies and associations.

This central machinery is appropriate and adequate for central purposes—that is to say for assisting the Minister to reach decisions on broad operational policies on the development of the Service—but at present the full value cannot be obtained from it because of the absence of important appropriate data. Decisions of this kind must be made centrally and cannot be delegated to local level, nor of course to independent self-appointed groups—if such should exist!

On the other hand, decisions relating to the strength and adequacy of a local service, the extent of any local need which is unmet and the formulation of day-to-day management or operational policies to meet such a need should be a local responsibility. The difficulties at local level are not so much that some essential data is missing but that it is not available at the right time and may not be seen by all those whose comment and co-operation is necessary before appropriate action can be taken. It is the machinery for consultation and decision taking which tends to be deficient at local level and this is particularly marked where a problem of medical care concerns more than one of the main branches of the Service and—most regrettably—where concerted action by the local medical profession as a whole is required.

I have tried to put need and demand in the perspective which I feel is necessary

and I would now like to turn to the question of the data needed for resource planning.

We have a fairly good knowledge of the nature of the services we now provide and of the resources which support them so far as the local health authority and hospital services are concerned and at both central and local level. However, appropriate data is still regrettably deficient in relation to the general medical services provided in general practice. The main reason for this is of course that general practitioners are separate individual contractors so far as the service is concerned and that there is no system of organisation such as exists in the other two branches of the Service. This is a serious handicap where the needs of resource planning are concerned.

There is a serious lack of reliable data from which we can obtain assessments of need and demand and by which we can judge the adequacy, efficiency and quality of the services in all branches of the National Health Service. Measurement of these factors is necessary both to make possible the effective control of existing services and for forward planning.

We need much more information on morbidity in order to assess real need, and more basic studies of use and consumption of services require to be undertaken. The development of norms and standards from the basic statistics of use are helpful not, as critics would have us believe, in order that we can force an undesirable uniform standard of mediocrity on an unwilling service but so that we can have some yardsticks which we can use in forward planning. We need to know whether a given service or facility is overused, underused or misused and what the results of this use are in terms of benefit to the individual patients concerned and to the community as a whole. We need to know this and to act on our knowledge not only in the formulation of national and regional policies within the administration of the service but also at local area level in the day-to-day working of surgeries, clinics and services. It is a matter for concern if a vaccination and immunisation service provided by a local health authority is not used or if an out-patient clinic is under such pressure that cases of serious illness cannot be seen within a reasonable time. Similarly it is a misuse of expensive specialised accommodation and highly trained staff if a hospital department which is designated as the accident and emergency centre for its area is crowded with cases of minor injury or illness which should more appropriately obtain any treatment which is really necessary at the G.P.s. surgery or even by resort to the contents of the bathroom medicine cupboard.

Unless adequate data is available we cannot deal with such situations or take surplus or deficiency into account in our forward planning.

It is with some of these needs in mind that in the hospital service the Ministry of Health introduced the Hospital Inpatient Enquiry in recent years and has followed this up with development of the wider and more comprehensive Hospital Activity Analysis system. The Department has also given substantial support to the Oxford Record Linkage Scheme—which links data from all three branches of the service—and has set aside special funds centrally to support operational research in all parts of the Service. The years ahead will see increasing use of modern methods of data handling and processing, and the importance of the computer has been recognised by government and accepted by the various service authorities. This is vitally important for the future; we must have proper information to plan effectively. In the field of preventive medicine the pioneer work of the West Sussex Local Health Authority in connection with its vaccination and immunisation programme has been outstandingly successful.

Resources

Let us turn now from objectives, needs, demands and what we seek to do, and consider the resources we must deploy in order to provide our services.

The problems of finance are always with us—both personally and corporately—and the difficulties are well known. I only want to note with satisfaction that whereas the proportion of the gross national product of the United Kingdom which was allocated to Health and Welfare was approximately 3·7 % in 1956, it rose slowly but steadily during the ensuing 10 years to a figure of just over 4·6% in 1966. This represents a very considerable increase. While we can hope that the trend towards more generous provision for our service continues, I think it would be unrealistic to expect that any much larger increase is possible in the future and unwise to adopt any such assumption for planning purposes. It is of course vitally important for resource planning to know as far in advance as possible what finance will be available. This may be difficult in the national context and the success of the Treasury in recent years in making more advanced information available has eased the planning problems considerably.

When we consider our other basic resource, man and woman-power, we meet considerable difficulties in forward planning. Although we have figures which tell us how many people we now have working in the National Health Service in various categories, essential data on the numbers likely to be available in future in the highly skilled professional groups which we need to employ is often absent. It is the future supply of trained personnel rather than of money which will be largely decisive in determining the nature of the services we provide and this is particularly important in regard to medical staff because of the big role of the doctor as the person with clinical responsibility.

Medical manpower is, in fact, an example of one group for which a substantial amount of planning data is available and the Department has for some years been increasing the volume and quality of information. For instance, we now have tables covering all grades of doctor working in the hospital service, analysed by specialty, sex, age, place of birth, length of service in a grade and for some grades showing age on appointment. As we have firm figures for the input of graduates from British medical schools the supply of trained or partially trained doctors at any level can be assessed with some degree of accuracy so far as United Kingdom based men are concerned although the picture is distorted by the very large number of overseas doctors we employ. Nevertheless we have a fairly good picture of our "supplies" in this field.

What we still require however, is information on the career path actually followed by doctors so that we can identify and analyse misuse of this scarce resource. For instance we must discover why it is that half of our Senior Registrar force of 1,369 (England and Wales at 30th September 1967) are aged over 35 and that 150 of them are over 40. Yet for the most part these are not "time expired" men because only 56 of them have been more than 5 years in this grade for which the conventional training period is 4 years. Furthermore, the last detailed examination of the numbers having more than 5 years service in the grade showed that a substantial proportion of them are occupying posts in famous teaching hospitals and were presumably "hanging on" waiting for particular "plum" jobs to be advertised. In that sense, therefore, they could not be regarded as victims of the system, but victims they certainly are in another sense for it is damaging to the individual and to the service if men cannot achieve appointment to an acceptable permanent career grade at a reasonable

age, and I would have thought that appointment by age 30 to 32 might be thought reasonable in this context.

There are, of course, many difficulties over hospital staffing and manpower which stem from the growth of the registrar grade and the use which has been made of so-called "registrar posts" in the Service. These undoubtedly contribute to the senior registrar situation which I have described. However, the problem of the structure and organisation of the training grades—urgent and important as it is—is not the main problem with which we have to grapple if we are to end the present unrest among junior doctors and enable effective resource planning to be undertaken in the key area of medical manpower. Our main problem is now, quite clearly, the nature, structure and organisation of the permanent career grades in the hospital service and the relationship of those grades to career grades in other fields and, most importantly, to doctors working as principals in general practice.

It is true that if the recommendations of the Royal Commission on Medical Education—the Todd report—were to be accepted we would see the introduction of a new "hospital specialist" grade which would be much more acceptable than the existing medical assistant grade. But the way in which this new grade would fit in with the general structure is not at all clear and I do not believe that this innovation alone can solve our difficulties or provide the answer we need. In plain words, our problem is the consultant grade.

The concept of the consultant grade has remained virtually unaltered for 20 years since the Spens Committee reported in 1948 and—make no mistake—has served us very well. Had conditions remained static we should no doubt be wise to retain the concept unaltered for a further 20 years. But things have changed and the grade as it exists today no longer fits in with the practical requirements of the times. What is required is a new evaluation of the job to be done and of the relationship of the grade to the training grades and to other parts of the Service. At 30th September 1967 we had 22,547 hospital doctors (excluding an additional 4,600 or so G.Ps. doing G.P. type work in hospitals)—22,547 doctors of whom 9,129 were Consultants or S.H.M.Os. with a special allowance and a further 1,117 were Medical Assistants or S.H.M.Os. without an allowance. Thus the number without secure permanent employment in the service was considerably more than half the total force.

There are also other anomalies about this grade and this is an example of a situation in which limited resources of trained manpower cannot be deployed to the best advantage and in which effective resource planning cannot proceed because an established manpower structure first requires basic revision.

The Ministry of Health has been giving much urgent thought to this particular problem recently and it is one on which we need understanding and co-operation from the medical profession both senior and junior. We need to see that changes which are needed are achieved by evolution rather than by revolution and in my view all the signs suggest that the latter could be uncomfortably close.

However, medical manpower and staffing is only one of the many manpower fields of which we have to take account and about which we need relevant data in order to develop resource planning, and I have cited it only as an example and one on which I have some knowledge. We need to know not only about doctors or about any other particular grade but about *all* professional and non-professional grades. Much new research and more data are required.

For planning to be effective it is no good having exhaustive and comprehensive data for only some of the fields concerned. Resource planning involves the comparative use of resources in attaining a defined objective and the substitution of one type of trained personnel for another can achieve a significant improvement in the use of resources.

It is one of the big rewards for painstaking systems analysts or operational researchers or for those who seek to prepare the ground for effective resource planning that the preliminary processes involved can, and usually do, of themselves reveal anomalies or inefficiencies which when corrected go a long way towards the solution of the main problems. It is clearly half the battle to have decided that a particular demand does in fact represent a real need, to have taken action to ensure that resources exist in a form in which they can be deployed without waste and to have an accurate assessment of the present and future supply and of the existing situation.

Nevertheless the final task is far from easy and involves the relationship of resources to services provided. If we are to achieve our objectives with the resources available then the provision of a particular service cannot be justified solely on the basis that it is a necessary service or even that it is a good service which is both necessary and medically efficient.

A service can only be justified if, being a necessary service which is medically efficient, it also constitutes a better use of resources to that end than some alternative.

If all the resources and the results obtained from their deployment could be expressed in terms of monetary value the problem of resource allocation would be much simpler and this sort of exercise would be just another application of the results of cost benefit analysis which is common enough in industry and elsewhere. Unfortunately, in the field of medical care not only is it extremely difficult to set a value on the input of resources of the kind we deploy but it is virtually impossible to evaluate many of the "outputs" or "benefits" which accrue to the individual or to the community as a result of the provision of a medical service. However the fact that this is a difficult task does not relieve of the responsibility of trying to adopt the principles involved and in going as far as we can to apply these in part where this is possible and useful.

I should like to start with a simple example. Let us suppose that medically speaking it is possible to detect the existence of a particular disease and reach a firm diagnosis by more than one organisational method. Necessary examinations and investigations in each case might require more time from doctors, nurses or technicians. Having accepted that any one of perhaps 3 methods could achieve satisfactory medical and technical results it would be a problem for economic analysis to decide which method should be adopted. Such economic assessment would involve the relative value of the different types of staff involved in each method and the technique that would be the one which was most economically efficient.

When Service costs are in fact available which enable us to do such simple economic exercises and these are not only applicable to different ways of doing things within a particular branch of the Service but also to different ways of achieving a defined objective by using facilities in different branches of the Service.

As the simple exercise in economy becomes much more complicated and of particular concern to the doctor when the "input" concerns the exercise of medical skill and judgement or when the objective is less well defined and can be

expressed less in terms of benefit to the individual than in terms of general health or community benefit.

This year the Nuffield Provincial Hospitals Trust published a booklet entitled "Custom and Practice in Medical Care" which gave an account of a comparative study of two hospitals in Scotland and in Maine, U.S.A., and in discussion on operation for appendicitis pointed out that the average duration of stay for patients with appendicitis in Britain was 10.3 days as compared with an average of 6.4 days in the U.S.A. It was noted that in 1961 there were 142,384 cases of appendicitis treated in British hospitals and that if it was assumed that all these cases were treated in hospitals classified by the Ministry as "mainly acute" then the cost of hospital care at £25 5s. 10d. per patient per week amounted to £5,508,409. Had the earlier discharge policy followed in the U.S.A. been applied here then the cost would have been £3,422,626—a saving of £2,085,783, resources which could have been applied for some other purpose.

Now of course there can be no question of telling surgeons how long their patients should be in hospital, but this theoretical example gives some idea in economic terms of the effect of medical policy on the use of resources. Obviously if, after being put in possession of the facts, sufficient numbers of surgeons decided that they could reorganise their procedures without detriment to patients in such a way that earlier discharge became generally established, then more resources would be available for the faster development of newer services. These released resources might—for instance—be used for haemodialysis and/or renal transplantation for chronic renal failure or perhaps for more intensive provision for neonatal surgery.

It is when we are faced with high cost developments which also involve the expenditure of a lot of the time of highly trained staff who are in short supply that it is so important and so difficult to assess real need and to decide the extent to which the results of applying resources in a particular way are justified.

In June 1967 the Royal Society of Medicine held a symposium entitled "The Cost of Life" and published the papers and an account of the symposium in the November issue of the *Proceedings of the Royal Society of Medicine* (Vol. 60, No. 11, Pt. 2). In this most interesting publication there is a paper by Dr. D. N. S. Kerr of the Royal Victoria Infirmary, Newcastle-upon-Tyne, in which it is suggested that if all potential candidates up to age 54 were treated on intermittent dialysis, about £30 million per annum *direct* costs and over 10,000 staff might be tied up in treating 23,000 patients. It was also pointed out that equally staggering indirect costs would be incurred, many of which would arise out of the need to deal with the complications which still beset patients on regular haemodialysis.

In this particular case it can be argued that a considerable proportion of resources deployed in this field should be directed not so much towards the establishment of a comprehensive universal haemodialysis service as such, but more towards the development of that service in relation to and in concert with improvement in the techniques and efficiency of renal transplantation.

Decisions on the speed at which a service should be developed and on how much of our resources should be allocated to possible alternative approaches are ones which can only be taken centrally on the best advice available from those best qualified to offer it. As medicine advances some of these decisions involve broad moral or ethical issues in which the community as a whole is concerned and which cannot be decided on considerations of cost/benefit

assessment alone even within the limits which the nature of health care imposes on such methods.

Some of the criteria involved are universally understood and accepted by an overwhelming majority of the population which would for instance reject a proposal for euthanasia at a fixed age. The argument that development of some services should be pursued by the use of resources which would otherwise be expended in maintaining the health and prolonging the life of the very old, is not acceptable. In some instances, however, the issues are not so clear and the burden of decision is a heavy one. Nevertheless the practical situation demands that in future we pay more attention than we have in the past to quantitative assessment of the nature and extent of improvements in health secured by particular services and to comparative assessments of alternative ways of providing these. Existing services must be included in such exercises and, for instance, it should at least be open to consideration whether the need for preventative and remedial care of children of school age is most economically and effectively met by the provision of separate School Health and General Medical Services or whether some new arrangement might avoid much duplication of effort and cross reference and conserve valuable resources.

What are the lessons for future resource planning?

I offer no clearly defined forward path but I think certain points do emerge which require our attention in the future. The process of resource planning requires a supply of adequate relevant data from which to operate and this needs improvement in many areas. Those of us who are responsible for planning and administering the Service must pay more attention to the interaction of medical and economic policies and to the identification of alternative programmes. We need the help of the professions in identifying real need, in formulating new staffing policies to fit modern conditions, and in the development of the norms, indices and standards of use which will facilitate resource planning. All of us must accept the need for re-examination of old or traditional methods and the willingness of the staff to accept new methods of working and new job allocation within these methods when this is indicated is crucial to the future. A positive educational effort will be required to promote more general understanding and acceptance of the need to apply the lessons of economics to the provision of a medical care service.

Above all, the economics of health must be explained to the general public in simple terms. It must be clearly understood that all the services which are felt to be really necessary cannot be provided unless it is accepted that non-essential services, services of convenience and the non-essential aspects of essential services are curtailed or possibly abandoned altogether.

This will mean changes in the way in which services are provided and in the places at which they are provided as redeployment and concentration of resources proceeds.

As members of the public and of our own local community none of us have a right to claim that non-essential services shall continue to be maintained at particular hospitals or units for our convenience if this means that the essential needs of medical care cannot be met adequately elsewhere.

I have been urging the need for a new approach to the deployment of resources and for changes which should follow this. I should be very sorry if, in my enthusiasm to promote changes which I believe to be in the best interests of the Service, I had failed to give credit where credit is due and to make clear my own basic feelings about the Service as a whole.

The National Health Service is 20 years old and in common with many human teenagers is experiencing some of the difficulties of the transition to adult life. Certainly this is a time for reappraisal, for the turning over of new leaves, and for the adoption of more responsible attitudes towards some of the problems of the future. But it is also a time for celebration and congratulation on a childhood during which much has been achieved.

If I may, I should like to give a personal birthday message to the National Health Service on this anniversary occasion as one might perhaps address a teenager of 20 years.

I think I must certainly start in conventional terms and say "Very many happy returns of the day".

I would probably add: "You are not perfect by any means. There have certainly been a lot of teething troubles and growing pains through the years. Still, on the whole, it has not been too bad and I am sure you will cope adequately with the new problems which lie ahead". I think I would continue: "I do wish that you were a little less extravagant and had a better idea of the value of money; and you must try and look a little further ahead in this field than you have done in the past but on the whole I am very proud of you". I think that would be my message, and on that I will close my paper.

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Mr. W. R. Jeffcott, Chairman of the United Cardiff Hospitals, opened the discussion on Dr. Yellowlees' paper. Taking up a reference to advances in medical science and to it now being possible to give far more medical and nursing care to many more people than our resources could sustain, he drew attention to the tremendous technological advances which had been made in other fields, particularly in industry. There, improved methods in production and distribution had been deliberately devised not only to improve quality and service but also to reduce both costs and manpower. Stressing that he was speaking essentially as a layman, Mr. Jeffcott suggested that people were entitled to wonder why it was that almost every advance in medical science cost more money and demanded more manpower.

Referring to what had been said about the objectives and obligations of the National Health Service, he said that while the objectives were clear and comprehensive there seemed to be a built-in escape from our obligations because the need for treatment must be "reasonable in all the circumstances". Within such a concept, the ethical, moral and sociological problems were enormous. Who was to decide that a man was to die because we could not afford to save him? If ten thousand lives could be saved, there was no doubt that the money could be found. This posed the question—where should the line be drawn, and who should draw it?

Referring to the difference between "demand" for medical services and "need" for medical care, Mr. Jeffcott illustrated his point by referring to dental services. In general there was not a pressing public demand for dental care; but if a service were provided, as had been done at Cardiff, demand was encouraged and stimulated. In assessing "need" prevention must be included as well as cure; "demand" should cover services which were not made significant by public pressures.

It had been said that the Service might expect a small, though steady increase in the proportion of the gross national product allocated for its work. Would

implementation of the recommendations of the Royal Commission on Medical Education depend on this small but steady increase?

In considering the function of the central authority, there seemed a case for extension of central control to the setting up of the highly specialised and costly units. Central authority should be able to say "No" as well as "Yes" to some of these expensive projects. Only by so doing could the Service be rationalised and avoid duplication. The call for concentration of the hospital service was right. But it was necessary to explain the situation fully to the public so that they understood that improved services could only come from concentration because it was only in this way that the necessary savings in money and manpower could be achieved.

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One of the first points made in the general discussion was that in considering the problems of "need" and "demand", the special position of the general medical practitioner had to be remembered. He was the doctor of first instance. In the main, patients referred themselves to him; hospitals, on the other hand, dealt with patients who were referred by their doctors. The general medical practitioner had the opportunity to know his patients better than anyone else; and he was best able to appreciate the various factors which entered into the creation of demand for service. These included the personality of the patient and his general background which in its turn was determined by traditional values, attitudes of friends, family pressures, and the literature and press of the day. There were matters here for sociological study and for consideration by the executive and by the politicians. Ignorance of these factors led to anti-patient attitudes. Wide dissemination of information about these factors to Service personnel and not only to doctors was needed in order to improve their understanding of patients.

Another speaker, taking up the question of planning resources said that while of necessity planning had to be done centrally, the development of resources and the use of them was essentially a local matter. At the same time, resources could not be planned unless there was an understanding of how they were going to be used. Management training had a part to play here and there was a plea for more younger hospital doctors to be sent on these courses.

There had been discussions about, on the one hand, shortages of doctors and nurses and, on the other hand, increases in numbers of patients and out-patient sessions. The Service was not going to get very much more of the gross national product and the problem which had to be tackled was the management one of trying to relate shortages to demand or need. From a management point of view, "demand" and "need" were indistinguishable. In this connection, the work of Management Committees and their officers had to be examined. Committees had to understand that it was their responsibility to get priorities right and not to waste the time of people who ought to be planning for the future. There was support for this from other speakers and the point was made that Committees ought to have confidence in their officials and delegate responsibility to them. If regulations were a hindrance in this respect, central action should be taken. The further point was made that while Committees should be concerned with policy and leave details to their officers, it was part of their responsibility to watch the needs of patients and their happiness. The world of the patient was not considered enough and it was the duty of members of Committees, as laymen and women, to remember the patients' needs.

Referring to the question of finance, one member thought that the Conference was in danger of overlooking the fact that the country had not yet solved its economic difficulties. It had yet to be demonstrated that devaluation would work. It would accordingly be wrong and, indeed, dangerous to take it for granted that as much money could be spent on social services in the future as was being spent at the present time. The proportion of the financial resources of the public sector allocated to the National Health Service could be too high, not necessarily too low. He also took the view that within the total amount available the balance of provision might be wrong. If greater emphasis were put on prevention more people might be kept in productive employment and this might lead to a reduction in the demands on the other branches of the Service. If this were so, present priorities ought to be changed even to the extent of having a greater degree of "make do and mend" in the hospitals.

Another speaker suggested that consideration ought to be given to the raising of funds from sources other than taxation. It was not clear how future manpower and financial requirements were going to be met.

The attention of the Conference was drawn by another speaker to the number of subnormal children in hospitals and the proportion of all hospital beds which was allocated to mental disorder. There were also other patients who were in hospital for custodial reasons only. Costs could be reduced by the use of hostels and proper co-operation between hospitals and local health authorities. Yet another speaker thought that it was necessary for decisions to be taken on which services could and which services could not be supplied under the National Health Service. In this connection reference was made to the need for a dentist to get the prior approval of the Dental Estimates Board before embarking under the Service on certain kinds of treatment.

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Dr. Yellowfees, replying to the discussion, said that a number of speakers seemed to have been under the impression that he was of the opinion that there was no local job to be done in connection with resource planning. This was not so; resource planning had to be done at local as well as central level. It was not just a question of use of resources. It involved the interaction of the medical and technical sides of the Service together with the financial side.

On the question of which services were necessary, he said that it was axiomatic in the Health Service that the necessary services were provided. The point turned on the meaning of "necessary"; this was what the discussion was about and different people would reach different answers.

He recognised the very difficult and human problems which existed in relation to severely disabled children and old people, but suggested that this was a problem for each community to deal with in the first place rather than the Ministry. Questions could only be answered as the Service evolved.

Session 3, Part II Resource Planning

Dr. J. O. F. Davies, C.B.E.,
Secretary, Central Committee on Postgraduate Medical Education

I am going to concentrate on the optimal use of *existing* resources which, as Dr. Yellowlees says, are primarily manpower and money. The strange thing here, of course, is that the better use of our manpower is quite likely to lead us into the expenditure of more money. "Productivity", which in industry will probably lead to making more money, may in the case of the Health Service mean spending more money. An example of this is that the quicker the turnover of patients in hospital the higher the cost per patient week. I am particularly conscious of this, perhaps, because my former region has always figured prominently in the press as the one having the highest cost per patient week. The press never elaborates, of course, that it has the lowest cost per patient treated and the highest turnover of any region in the country.

I was grateful to Dr. Gibson for drawing attention to our need to see the health problems of the district which we serve as a task not only for hospitals, general practitioners and local authority personnel working together, not separately, but also for voluntary bodies and indeed the public, who must share in our work. Many, if not all, the ideas for providing a better, or increased, service by the hospitals involve placing additional tasks on those working outside the hospitals and it is essential to talk with them and involve them at every stage if we are to be successful.

I had wondered for some time before starting to prepare this talk how I should approach it. My interest in the past has obviously been mainly on the hospital side. I thought of the surgeon who operates on patients with a hernia and discharges them the same day and of how much better it would be if he could get everybody else to behave in the same way in suitable cases. Then I thought of the other people, apart from his immediate team, on whom the surgeon is really dependent for success—the hospital administrator engaged in making some of the arrangements and perhaps finding additional money; the nurses who help the surgeon and who probably have to make arrangements for the occasional patient to stay in; the district nurse who would visit the home and the general practitioner who would have to care for the patient under the supervision of the surgeon. It dawned on me that I was seeing treatment of this kind as being all due to the efforts of one man, whereas in fact it is due to the co-operative effort of the surgeon and all who work with him inside and outside the hospital.

My thesis, therefore, is that to make the optimal use of existing resources the district or the community must be seen and considered as a whole; that the only road open to us is better management and that this involves accelerating the bringing together of the arms of the Service which is taking place in many parts of the country. In the suggestions that I have to make for using present resources more effectively this idea will be behind everything I have to say, and I hope you will consider them in this light.

First I should like to pay tribute to the way in which all branches of the Health Service have been moving towards making the optimal use of their existing resources. Dr. Reid has told you of the variety of close links that have been forged between the public health services and general practitioners; how

public health staff have been attached to individual practitioners. I do not propose to go over this ground again but I am very conscious of what has been achieved in the better use of available resources by local health authorities.

General practitioners have grouped themselves together and are moving towards the large practice groups forecast by the Royal Commission on Medical Education which will have economic and professional advantages, as well as advantages for patients, and the upsurge of interest by general practitioners in health centres in the last few years, although they were first mentioned by Beatrice Webb about fifty years ago, is truly remarkable.

The hospital services treated, over the ten-year period 1956-66, 36% more in-patients in a slightly reduced number of beds. Indeed, our progress since 1948, as measured by the increase in patient turnover, is the equivalent, according to Avery Jones,¹ of having built one hundred 800-bed hospitals, and this at a time of complexity of medicine as you have heard it described by Professor Butterfield. This is no mean feat. It has been achieved by shortening the stay in hospital, early ambulation, powerful drugs, more effective management and the most devoted service by staff of all grades. Let us not be mealy-mouthed about this last.

Criticism has tended to be levelled at the way in which the Service has failed in efficiency because of the division between the different branches but it is only when one looks at the whole that one realises how great a movement throughout the twenty years there has been towards co-operation. And co-operation, of course, is what we have to have. We may change the administrative structure of the National Health Service, but without co-operation we may not be much better off than we are now and I come back to my thesis that so far as possible the district must be seen as a whole.

In the light of what has already been achieved how can we now use our resources to even better advantage? Inevitably, since the hospital service is the most costly and sophisticated, it must be here that we mainly look for pointers to better management.

Admission to Hospital

The complexity of medicine and the dependence of one specialty on another is now such that effective hospital medicine can really only be practised in the district general hospital with all the disciplines represented. This is not happening now and we must find some way of dealing with the many patients who are kept in hospital for other than medical reasons. It has been shown many times that between 20% and 40% of patients in hospitals at any one time are really "self-care" patients, many of whom are, or could be, up and about. Discharge may be difficult to arrange for a variety of reasons but a visit to hospital by a district nurse or a health visitor to discuss with the nursing or medical staff the home situation and the needs of the patient may well go some way towards freeing beds.

Duration of Stay

There are at present wide discrepancies between durations of stay for the same condition at the same hospital and, curiously enough, in the practice of the same surgeon working in different hospitals. Some hospitals accept early discharge and practise it. But in hospitals where early discharge is as yet a new

¹ *The Hospital*, Vol. 63, No. 6, June, 1967 pp. 217-220.

feature one way of preparing for it is to have a trial period during which patients are allocated to an early discharge group but retained in hospital. At the time of discharge the period between possible early discharge and actual discharge is examined and the problems reviewed to see which had arisen capable of being dealt with only in hospital. These trials of early discharge do in fact lead to an early discharge policy.

The early maternity discharge scheme initiated by Theobald¹ in Bradford actually provided the margin to improve ante-natal treatment and reduced toxæmia deaths. Even so, maternity apart, there are a number of other countries, notably America and Switzerland, where the duration of hospital stay is much shorter than that in this country. We have known for a long time that if the length of stay in all regions could be reduced to that of the shortest, or even the performance of all hospitals in one region could be brought up to the same level, many more patients could be treated in hospital.

Changes in treatment may alter the picture, too. George Fegan of Dublin introduced some years ago a treatment by injection of varicose veins,² which I understand has been tested and found to be effective over the last few years. In 1966 it was estimated that 70,000 bed days were saved by the adoption of this technique.

A number of general hospitals have in the last seven years led the way in the admission of patients to hospital for a period of treatment of five days. This was not a situation of choice but determined by the non-availability of nursing staff. Nevertheless, the situation was turned to advantage and now there is a whole range of experience of the kind of patient who can be admitted on Monday and discharged home on Friday with safety. Again this involves the collaboration of the general practitioner and the local authority services.

Out-patient Services

I want now to say something about out-patient services. I wonder if some of the post-operative reviews involving the attendance of patients in the out-patient department are essential if we have to spread our medical skills? If the patient were told what to expect in the recovery period and where to go, either to the general practitioner or to hospital, if anything untoward occurred, might we not cut on these re-visits? Is it true that junior medical staff have some hesitation in discharging re-attenders from the out-patient department? Might restricting some of the re-visits, combined with senior medical opinion readily available, reduce the total of attendances and allow of the easier attendance of more new patients?

Are there not a number of conditions in which patients receive dual care from their general practitioners and the hospital? A national survey of hospital practice³ showed some hospitals never discharged a patient with diabetes, doing it all themselves. Other hospitals discharged patients to the care of their general practitioners, while still others discharged their patients with an arrangement for a yearly review.

General practitioners must be aware of the hospital policy if they are to play full part in the care of their patients.

I was going to say something about day hospitals but you have already heard about them today. Suffice it to say that I think in due course, with adequate

¹ B.M.J., 19th December 1959.

² The Lancet, 29th February 1964.

³ Unpublished, Ministry of Health.

facilities, every general hospital can develop a day hospital, apart from the particular psychiatric and geriatric hospitals which are now doing such a good job.

Diagnostic Services

Our diagnostic services are under hard pressure. Both in-patient and out-patient services are very dependent on laboratory and X-ray services and the volume of work of the diagnostic departments has increased beyond imagination. Whilst there are considerable fluctuations in the demands on these departments, these are capable to some extent of being predicted. Although X-ray departments have appointment systems, and laboratories have solved some of their problems in the recruitment of technicians by automation, these are not enough to help them out of their difficulties.

How often do the main users of diagnostic services consult regularly with the suppliers? Much profit might come from discussions between users and suppliers.

Many letters from doctors to consultants are not opened until the patient presents himself in the out-patient department. If it were possible to arrange for letters to be opened and read beforehand, this, combined with open access by general practitioners, together with locally agreed and published policies, might help both the diagnostic and out-patient departments to function more efficiently.

Manpower Conservation

When considering the conservation of manpower, one of our two basic resources in short supply, the attendance of consultants at peripheral clinics, needs careful evaluation to see whether consultant time is being used economically. Many such clinics are much less well attended than those at the main hospitals; they do not as a rule possess facilities for investigation and attending them may involve a great deal of travelling for the medical staff. However desirable they may once have been thought, choices may now have to be made as to how best to use highly skilled time. Similarly, operating sessions at small peripheral hospitals, where there are not full facilities, seldom allow as useful a day's work, or as effective post-operative supervision, as in the main hospital.

Whilst no one wants to disregard patients' travelling time, it may in many circumstances make for the more efficient use of consultant time if patients in fact do the travelling. This, of course, would make even more important an effective appointment system in out-patient departments.

Discontinuing a service is in many cases difficult and the clamour raised, often in mistaken pursuit of convenience at the expense of efficiency, tends to prevent this being done. Nevertheless, there are many occasions now, and there may well be more over the next ten years, when this is the best thing to do, call for courage as it may.

Divisional Systems

I want to say a word on the divisional system. Dr. Reid waved the "Cog-wheel" booklet at you this morning and although he touched on its contents perhaps you will allow me another few words on it.

The first report of the Joint Working Party on the Organisation of Medical Work in Hospitals¹ recommended that medical staffing in hospitals should be

¹ H.M.S.O., 1967.

remodelled on the basis that members of specialties falling into the same medical or surgical categories should be grouped to form divisions, under the chairmanship of one of their number. The proposals of the Working Party have on the whole been well received and have as their intention the better management of medical resources within the hospital.

The functions of the division will include the review of the use of hospital beds against the background of the community needs and the organisation of out-patient and in-patient services. They will include also a review of clinical practice and the organisation of vocational training and further development of post-graduate medical education. They are not meant to reduce the clinical freedom of the individual consultant but only to set before him the facts of the division's performance. One of the chief intentions in this change is that bed allocations should be flexible as between consultants and that there should be movement away from the fixed allocation of beds to which Mr. Freeman referred and from which he would wish to depart.

I do not propose to dwell on this divisional structure. I have been greatly cheered by the general acceptance of the ideas put forward, particularly by the acceptance of them by officers of the Hospital Management Committees and hospitals themselves. I have no doubt in my mind that the Secretary of a hospital, an H.M.C. or a Board of Governors has a most important part to play in the effective performance of hospitals and that he should be involved up to the hilt in the formulation of policy of all kinds and completely in the picture about what goes on in every department of the hospital. His contact with the community services needs to be continuous to be effective and unless one has experience of the job which these men carry out one is surprised at how much they are responsible for the smooth running of hospital services.

The General Practitioner and the Hospital

I should now like to refer to the relationship between the general practitioner and the hospital.

The future of general practice has been the source of much speculation in recent years but in this country there is no large-scale movement towards direct access to a consultant. Patients, save in emergency, still reach the specialist only on the advice of the general practitioner, who chooses the specialist to whom he sends his patient. These two groups of doctors are not in competition with each other; their division is one of function within the profession and individual members are more or less dependent on the others. This is a recognition of the impossibility of one doctor being solely responsible for the care of patients.

The relationship of the general practitioner to the hospital service has still to be worked out. I am not giving you any solution to this problem but just suggesting four possibilities.

Should the general practitioner have total clinical control of patients in acute beds, with access to consultant advice as required?

Should he care for patients in hospital beds suitable for illness normally treatable at home but for which the social situation demands admission to hospital, the clinical control to be entirely that of the general practitioner?

Should he have an association with a hospital team which brings his expertise into hospital for the benefit of patients in special departments?

Should he pursue a special interest, with an appointment to the staff of a hospital for part of his time?

It may be, of course, that we can use all four of these ways of associating the

general practitioner with the hospital. I can see the Chief Medical Officer looking a bit glum here and thinking that I do not know that the hospital service got 800 additional doctors last year while general practice got 4. We are really looking a long time ahead, however, and I am not expecting this to happen next year, but I am sure that the general practitioner should have as much association as possible with the hospital service. This is part of my thesis.

The role of the cottage hospitals is not really clearly defined. Their present siting is based on local history and the communities now possessing them would not necessarily be those having the highest priority for in-patient facilities if the position were to be looked at afresh.

Various methods of organisation are being introduced into group practice and theoretically better organisation should make available to general practitioners more time for new interests. This time saved is available for other purposes but it is important that it should not be used on tasks which might be undertaken by other workers in the medical field. The role of the general practitioner needs to be examined in the light of optimal use of medical manpower and the unification of medical effort.

Many of you may be interested in the integrated Health Service which is to be based on the district general hospital of the new town now being built at Livingston in Scotland. Staff appointments have been made available to general practitioners who work from one large health centre and a number of subsidiary centres. The main centre will house the normal local health authority services and provide diagnostic facilities for general practitioners working there and at the subsidiary centres. Each practitioner will develop some special interest which he will exercise in his hospital duties. This may be a pattern which could usefully be followed south of the border.

Operational Research

I should like to say a word or two on operational research before coming back to my thesis.

Both Dr. Reid and Dr. Yellowlees have emphasised the need for factual information and Dr. Yellowlees has mentioned the Hospital Activity Analysis¹ which is now under operation in whole or in part in some 60% of Regional Hospital Board areas. This aims to provide factual information on what happens in wards and a feed-back of this information to the individual hospital or group, such as a complete diagnostic index and details for each consultant summarising patient load and other clinical facts which by design have been recorded. To be effective, of course, this information must be provided soon after the event.

It is hoped that a suitably modified hospital activity analysis will in due course provide a feed-back of information to clinicians about individual patients, thus relieving them of what is often a daunting task at the present time when they wish to abstract for study perhaps 100 or 200 cases of whatever condition they particularly want to investigate.

The most outstanding example of close examination of work done—for that is what we mean by feed-back—is the confidential enquiry into maternal deaths. This has been undertaken now for a number of years and the results are published every three years.

The true maternal deaths for 1967 are one third of the number which would

¹ Benjamin, B., *Pro. Roy. Soc. Med.*, 1967, 60, 809.

have occurred had we still the same death rate as in 1950. There were 170 deaths last year, including abortions, and the death rate without abortions is as low as 16 per 100,000. I am sure that it is generally accepted that this close examination of work done is very worth while.

We are moving into the era of automatic data processing and before long each Regional Hospital Board will be assisted by a computer so that it will be possible quickly to retrieve information which now once recorded is often lost forever.

The provision of sound statistical data concerning work performed is the basis for operational research in any context. Dr. Yellowlees has told you that funds are being made available for operational research and indeed some 200 studies are in progress. Here I should like to pay tribute to the Nuffield Provincial Hospitals Trust and the King's Fund, which for so long have devoted their energies and their finance to work of this kind.

There are two main problems about operational research; the first is to find the people to carry it out and the second is to prepare the people with whom you are going to work for the research you intend to undertake. Studies of this kind do tend to arouse, unless carefully presented, quite deep emotion. I know how I felt some years ago when my department underwent an "organisation and method" study, which, whilst not operational research, arouses similar feelings in the person being studied. The best results tend to come when the need for study is put forward by those being studied. In one large hard-pressed 1,000-bed hospital a recent investigation by the staff themselves showed that there were 200 empty beds every night; 80% occupancy of 1,000 beds means just that. A group finding the problem for itself will be receptive of suggested solutions.

I think we need to look at the way medical staff at all levels work, with a view to making them work not harder but more efficiently and in many cases more easily.

Similarly with nursing staff. The Prices and Incomes Board recently told us that there was no overall shortage of nurses but that they were not being properly used or deployed throughout the Service. Nurses are in fact learning more technical skills all the time, for example monitoring electronic equipment in intensive care units.

The Central Midwives Board has recently agreed to midwives extending their activity to technical operations not previously performed. And many nurses now undertake tasks at one time thought to be the prerogative of the doctor.

I think we could achieve very much more by discussion between nurses and doctors in hospital. To my shame it was not until 1966 that I brought my nursing advisory committee and my medical advisory committee together at one meeting.

I am sure that in radiography and physiotherapy departments, and in the field of social work, study can give us more technical time. We are greatly indebted to all the professions supplementary to medicine and any investigations which extend their expertise are well worth while.

The size of the National Health Service in terms of personnel is such that there should be a central manpower studies unit responsible for the analysis and development of relevant research and perhaps also responsible for carrying it out directly or indirectly, using, say, university departments.

Priorities

I want to support all those who have said today that we must have discussion with the public. Public opinion does much to influence priorities and in so doing

the quality of care in medicine. In maternity provision we are steadily moving towards complete hospitalisation and this is clearly now to everyone's satisfaction. Increasingly is there acceptance of early discharge from hospital after confinement or after certain kinds of surgical operation.

Public interest in the problems of sick old people or in the mentally sub-normal is nothing like so great. Interest in mental illness has grown with the years in the National Health Service and the number of doctors in this field has grown with it.

The number of doctors in geriatric medicine however, is woefully inadequate and yet this form of care, far from diminishing, is going to grow for many years. The fact that half our beds are devoted to geriatrics and psychiatry does not mean that half our staff should similarly be allocated. But there seems to be a general acceptance that the staffing of our hospitals for psychiatric, geriatric or mentally sub-normal patients is inevitably difficult on the nursing side.

One can add to these groups the young chronic sick.

Our share of the gross national product has gone up from 3.7% to 4.6%. If this share is not to go up steadily it means that choices have to be made.

Nobody wants our hospitals to lag behind in advancing the growing edge of medicine. The funds to support such advances should, however, be separate from those needed to support the kind of activity which I have now mentioned. Both the Medical Research Council and the Ministry of Health do of course support research in just this way.

But the situation remains that public opinion can influence priorities and consequently resources and thus, in the end, the quality of care given.

Public opinion can, of course, be influenced by open discussion of the points at issue. Indeed there is no other way of influencing demand save by open discussion. The effort and efficiency with which the public is kept informed about the facts of health education and the proper way to use the services will in large measure determine demand for service.

The Community and the Hospital Service

As I have said already, there is a recognition of the impossibility of one doctor being solely responsible for the care of patients.

Generalist and specialist practice, then, must become increasingly inter-dependent as the sophistication of medicine increases. This cannot be achieved with all the specialists inside the hospital wall and hardly ever looking out. There must be a meeting ground and the development of more than 200 post-graduate centres in regional hospitals since 1961 offers one hope of providing this.

Our thanks are again due to the Nuffield Trust, which has done so much in furthering postgraduate medical education.

We are moving towards the concentration of hospital services on district general hospitals but we cannot treat the hospital as an organised centre of unorganised unscientific medicine outside its walls. The district must be regarded as being served by the district hospital and a complex of group practices, with all the doctors working in them meeting in the postgraduate centre, within which there is a free flow of information in both directions.

"Best Buy" Hospitals

The new "best-buy" hospitals,¹ and I am sure most of you will have heard of

¹ The Lancet, 6th April 1968, p. 761. B.M.J., 13th April 1968, p. 113.

them since the Minister has appeared on television demonstrating them, have been devised by the Ministry. There are two of them, identical, and they will be built at Bury St. Edmunds and Frimley. Though conceived as a technique of cheaper and quicker building, in which we must all be interested, much more important so far as my thesis today is concerned is that they are based on the concept of area planning which will bring about an integrated system of medical care.

These new hospitals will provide half as much again in the way of out-patient facilities, diagnostic departments and operating theatres in relation to beds as is being provided in our newest hospitals now.

The intention is to provide special facilities for investigation and, where possible, treatment of patients in the out-patient department. There have been pioneers who have undertaken day surgery for many years. The number of their followers steadily increases. But these facilities are not for surgeons only.

Nobody wants patients to be discharged home early, or on the same day, to circumstances which are inappropriate, and in every case it will be necessary to make arrangements beforehand with general practitioners and local authority services. The "best-buy" hospital will work only if it is seen to be part of a larger whole.

This concept of area planning will carry the hospital into the community and will allow of the involvement of the general practitioner in hospital clinical work. Involvement in early discharge schemes, with access to diagnostic services which the G.P. now has, and will have increasingly in the future, and the developments in postgraduate medical education and of health centres, are steps towards overcoming the professional isolation from which the general practitioner has suffered, and these same steps provide an opportunity for some of the specialist knowledge that is applied to hospital practice to be diffused more readily into the general practices.

The techniques, then, by which we can hope to measure up to the tasks before us are predominantly those which bring about a situation in which the arms of the Service work more closely together. As I have said before, we can only look for a better management of our resources to meet the problems ahead since the possibility of any substantial increase of personnel in any short period of time is simply not with us.

I am sure that this better organisation to which I refer is open to us and is well within our capacity.

* * * *

Mr. R. Brinley Codd, Treasurer of the South-East Metropolitan Regional Hospital Board, opened the discussion on Dr. Davies' paper by referring first of all to his references to the need for better management. Everyone who had control over resources was a manager, whether the fact was realised or not. He wondered whether doctors generally appreciated their function as managers; in fact, they had the use of resources in every clinical decision they made and it was just as important that doctors, as well as all other staff, should see fully the need for effective management at all times.

To be a better manager, a doctor needed certain information. He ought to be provided with details of the cost of in-patient care, out-patient care, and of the running of the various medical service departments. These costs needed to be linked with clinical information to be meaningful; in other words, as Dr. Davies had said, "sound statistical data of work performed is essential".

But it was in future planning as well as current activity that resource planning was an important matter. There was a need for co-operation and for a multi-disciplinary approach on the part of all hospital staff for the effective use of resources whether these resources were labelled as capital or revenue. For the proper planning of a capital programme, consortia of officers including those representing medical, administrative, financial, nursing, architectural and engineering interests were necessary. In planning revenue expenditure year by year a similar approach was needed as it should be directed towards total resources, not merely the annual revenue increase.

It had been said several times that resources were insufficient. But in the existing economic climate the ever-increasing financial burden resulting from advances in medical science and technology could be met only by the elimination of waste and the promotion of efficiency. The way out did not lie in cutting back on maintenance programmes: this was false economy.

Mr. Codd reminded the Conference of various instruments of financial control—budgetary control, management accounting and costing—and of the pending publication of hospital costs for 1967/68 which, for the second year, would be on a common basis for every hospital in the country and show full departmental accounting. But it was one thing to produce costs and another to use them intelligently and effectively. Far too often attention was paid to the average costs of a hospital of a certain type and investigations confined to those hospitals which were markedly above or markedly below the average. Increased revenue allocations had been sought because hospitals in a group were low-costed. But costing results should not be considered as indications of inequality of revenue allocation, measures of need, or measures of efficiency; hospitals were not comparable one with another and overall figures could not be used as yardsticks. To help assess the right cost for a hospital it was necessary to evaluate its activity, that is, take into account the distribution of beds by specialties, bed occupancy, length of stay, turnover interval, the strength of medical and nursing staff, the quality of management and the workload falling on the various medical service departments. Of these, quality of management was perhaps the most important. There was a need for an extension of the activity of the Ministry's Central O. and M. Department in conducting detailed surveys into management at hospitals. Hospitals themselves should apply the same techniques.

The requirements of management called for a unified career structure for the hospital service, particularly in the administrative and financial branches. The present standard of recruitment was very poor. The Whitley Councils should turn their attention to this matter.

Reference had been made to the use of computers which had been used for financial work for four or five years. They were, however, only slowly being used for hospital activity analysis and patient monitoring. It had been said that hospital activity analysis was operating in 60% of regional areas at present; while this might be true, it was not operating in depth and there was a long way to go before standardisation would be effective. At the same time it had to be remembered that computers were undoubtedly expensive tools of management.

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Professor Butterfield intervened in the general discussion to say that it was unfair to surgeons and the producers of modern drugs to imply that advances in medicine always cost money. It was these people who had enabled the Health

Service to contain modern treatment within the same number of beds as had been provided in 1948. It was wrong for those concerned with finance to look upon research workers as people who were engaged in dreaming up expensive projects.

The use of hospital beds was taken up by another speaker. Early studies of the demand for acute hospital beds had shown very wide differences from one area to another, but as demand approximately equalled supply many people came to believe in a Parkinson's Law of hospital provisions, i.e. demand expands to occupy the number of beds supplied. The 1962 Hospital Plan set norms for planning purposes; for acute beds it was three per thousand population. This seemed right at the time; but it now seemed right to acknowledge that some areas were healthier than others. This had been clear for a long time from mortality statistics. Urban areas were worse affected by bronchitis, lung cancer and heart disease than rural areas; and there were regional differences in urban mortality. These factors, together with social class differences accounted for differences in need for hospital facilities. It was to be noted that the Ministry had recommended two acute beds per thousand population for their "best-buy" hospitals which were in quite healthy areas.

Flexibility in the use of beds must also be considered. Patients were sometimes moved around within a hospital as consultants generously lent a bed here and there for a day or two. This was mismanagement and could be avoided if beds were not rigidly allocated to consultants. Allocation could be by larger groups of specialties—the "Divisions" of the "Cogwheel" Report and the Royal Commission on Medical Education. An alternative which could be introduced into existing hospitals with less reorganisation was the pre-discharge ward. Pre-discharge beds might account for about one-tenth of the total number of beds in a hospital. They could be available for the last few days of a patient's stay and be used for either sex from any specialty. The result would be a measure of flexibility with variations in demand in different departments being levelled out. It should be possible to make such an arrangement without building new wards or increasing the number of beds. Whether this solution was followed or some other, a way had to be found of introducing flexibility in the use of beds.

Dr. Yellowlees intervened in the discussion to say that he believed in norms for beds as used and not for beds as allocated.

In further discussion a speaker said that every effort must be made to avoid misuse of staff. It was essential that work studies be carried out and analysed. Studies so far showed a need for a staffing structure within local health authorities; for example, registered nurses, enrolled nurses and auxiliary nurses ought to work together in a team attached to general practitioners. In this way, job satisfaction would result. Greater use should be made of part-time staff and this meant that good in-service training should be provided for married women so that they could feel confident to carry out their duties. Local authority nurses welcomed opportunities for working closely with hospital staff; and where such arrangements enabled student nurses and pupil nurses to spend part of their training time on the district a great advance in nurse training could be made.

Another speaker warned that if the aim was solely greater efficiency a great deal of job satisfaction might be lost.

The impression given to the Conference about the quality of administrative and clerical officers was challenged by a speaker. In the last 10 years a considerable number of first class administrators had been recruited. The group at

present in training were excellent material and they were enthusiastic. There was no need to be down-hearted about the quality of administrative recruits. On the clerical side, there had been an improvement in quality, if not in quantity. The future was hopeful.

There was a strong plea by one speaker for a re-examination of the activities of the separate branches of the Service before integrating them into a new structure. Each branch had changed immensely in the last 20 years—the hospitals had become increasingly specialist there was a revolution under way on the general practice side and local health authorities were encompassing a tremendous range of functions some of which were difficult to identify and define. Without a review of what each branch was doing today some vital function might go unrecognised and a corresponding need would not be met by the Service in its new form.

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In replying to the discussion, Dr. Davies said that he agreed with all the remarks that had been made about the need for doctors to be made more aware of their function as managers. If they called for investigations, or if they undertook treatments that involved the use of people, materials, equipment, time, etc., they were managers, whether they knew it or not. One of the aims of the "Cogwheel" Report was to bring home to consultants that they were managers. If they realised that they were using resources in this way and were conscious of being managers, they might do the whole task much better and much more economically. The last chapter of the "Cogwheel" Report referred to the need to indoctrinate those who were to be chairmen of divisions, and there were a number of courses that were planned experimentally to see the kind of useful teaching that could be given to consultants on management in medicine.

On the question of empty beds, either a common admission ward or a common discharge ward might well improve the situation. But it was very difficult to persuade people to take a ward and turn it into a discharge ward. The solution was quite often to have a different working pattern, to cull some of the existing resources and put them to another use. In a large hospital it should be possible from within existing resources to make necessary changes.

The idea of determining bed requirements on an area basis could be agreed. It was a fact that in the "best-buy" hospitals to which he had referred the acute bed provision was approximately two per thousand and not three per thousand as recommended in the Hospital Plan. While he would have every sympathy with the idea of experimentation, if it were practicable, in certain well-defined and prescribed local areas, it would not be easy to set in motion.

On the question of keeping personnel in the Health Service, job satisfaction was more important than pay. There were much better prospects of holding personnel if jobs which were not filled could be orientated or re-orientated to provide job satisfaction.

Session 4, Part I Manning the Service

Mr. A. D. Bonham-Carter, T.D.,
Chairman, Board of Governors, University College Hospital

On 12th March 1968, the Minister of Health was asked, in the House of Commons, whether he had any plans to mark the twentieth anniversary of the birth of the National Health Service. In a written reply, Mr. Robinson said that he was arranging a Conference. He added that his intention was not only to mark an important stage in the development of a great service but also, more importantly, to help to shape and fit the service for the tasks that lie ahead.

I have been rather careful to quote the words which the Minister used because I regard them as significant. We are marking an important stage in the history of the National Health Service and that, by itself, would be a good reason for me to ask you to take a look backwards at what has been achieved: as Miss Jennie Lee said, you must see from whence you came in order to know where you are going. But it is even more important to look forward, so I shall try to confine my historical remarks to things which are relevant to the more important part of my subject which is "Manning the Service". The title, surely, implies plans for the future.

It is, I think, relevant that we have long had strong objections to manpower planning on a national scale. These objections are based on an attitude of mind which regards the law of supply and demand as being both sacred and the eventual answer to the majority of economic problems. It was a view which was widely held by economists in the nineteenth century. The validity of the argument began to be questioned some sixty years ago, but the First World War did not produce anything very sophisticated in the way of a manpower policy and substantial progress had to wait until 1939 and the coming of the Second World War.

Many of us here will have to admit, however much it dates us, that we can remember the work done at that time by the newly-christened Ministry of Labour and National Service. What we may not recall so clearly is the gigantic task which they faced at the outset when they had virtually no information of any kind to help them. The reason for this was, very largely, this historical British attitude to any form of central control including, of course, a manpower policy. Interestingly enough, the same attitude prevailed outside government circles and the use of manpower came woefully low on the list of priorities in commercial and industrial enterprises. They were times of unemployment when labour was comparatively plentiful and cheap, so there was much less feeling of urgency to economise in labour than there is today.

After the War, the Government was faced with the problems of reconstructing the economy and, as an important means to this end, a Control of Engagement Order was introduced; but the country, understandably tired of wartime restrictions, would have none of it and, as it failed in its purpose, it was soon withdrawn. Since then, we have had the Selective Employment Tax with which we are still experimenting; one must admit that in its original shape it does not seem to have had the desired effect of diverting labour to any material extent into the more productive channels.

Two things come out of this. The first is the fact that the country has a long and lasting objection to anything resembling direction of labour. It seems that

hitherto, at any rate, it has only been acceptable when there is a crisis of a kind which is clearly recognisable by everyone as a threat to the way of life of the man in the street—e.g., a modern war. The second is that, as a moment's reflection will show, times of unemployment have not been conducive to progress towards a manpower policy (e.g., the decade before the war) so that when, in times of full employment, one has really needed it, it has not been there.

I have asked you to approach this problem of manning the National Health Service in this way because I think it is necessary to understand something of the difficulties which faced the Ministry of Health in 1948. They took over with a stroke of the pen, as it were, hundreds of hospitals of all kinds, many of which were already inadequately staffed and they had no reliable estimates of future demands.

With this unpromising start, the achievements of the last twenty years are worthy of our attention. I do not propose to trouble you with a host of figures and I must bear in mind that my concern is manpower, but manpower represents some two-thirds of the money voted for the Health and Welfare Services so the financial figures are highly relevant.

In the last ten years, for example, the Health and Welfare Services' share of the Gross National Product has risen from 3.7% to 4.6%—an average increase of 0.09% annually. If this does not strike one as being substantial, it should be remembered that in 1966 (the second of the two years I have mentioned) 0.1% was of the order of £30 million.

Let us look at this thing from one or two other angles. In 1953, the Medical and Dental Services employed 2.9% of the insured population and 6.7% of those in the public sector. Ten years later the comparable figures were 3.6% and 7.6% respectively. These are both increases of some importance. Alternatively, look at another vital series of figures. In the five years 1955 to 1959, the intake of the medical schools was 9,600; the expectation is that in the current quinquennium, 1965 to 1969, the comparable figures will be 13,000—an increase of 35.4%. On the nursing side, the total number of hospital nursing staff in 1955 was 165,862—in this case I have the 1967 figure, which is 252,509—an increase of 50%.

It is not part of my duty to go into any detail of the many new hospitals, out-patient, casualty and diagnostic departments which have been brought into the Service since 1948; but I do want to remind you that they all have staffing implications which contribute to the feeling that we are short of both money and manpower; indeed we are, but we always will be and it is as well to bear in mind some of the problems of 1948 and something of the achievements of the last twenty years. Perhaps it is worth making the comment, almost as an aside, that shortages of doctors and other highly skilled people is an international or worldwide problem. Richer countries will always buy skill and ability from less rich countries, and the poorer countries will always be compelled to have some of their own potential going abroad to acquire training as well as having to buy or borrow skilled men in return. But for another reason we always will be short because there is, as far as one can see, no limit to the level of medical service which we can provide. In other words, the limitation is always likely to be set by the money and the manpower rather than the fact that we have reached the end of advances in medical knowledge and skills. That being so, we are faced with a fundamental and perhaps insoluble difficulty in the way of deciding upon our manpower policy in a conventional way. The Office of Health Economics posed the problem with clarity in their booklet entitled "Medical Manpower",

published in July 1966. The paragraph on "The Future" opens with this sentence: "The present acknowledgement of a shortage of medical manpower begs the question of 'a shortage in relationship to what?' " They go on to say, "the real problem lies not in absolute numbers but in defining anew the role of the doctor and deciding on the quality of medical care which Britain should afford to provide for itself."

Where, for instance, will we stand by the middle of the seventies with some of the most recent and dramatic developments? What is success for some of these wonderful achievements anyway? Is it prolongation of life by six hours, six days, six weeks, six months, or what? What justifies making these things widely available in the National Health Service? These are frightening questions involving ethical aspects as well as economic ones—and there are certain to be further advances even before the young people entering the medical schools this year have qualified. There are other unknown factors, too: what will be the ultimate effect on staffing of the recent legislation on drug addiction and abortion?

Normally a manpower policy demands an initial forecast, by quantity and qualification, of the number required to achieve an agreed level of service at a certain date: that date cannot be earlier than the time it takes to provide the facilities for training the men and women entrants, plus the time it takes for the actual training of them. Nor, of course, can the forecast stop at that point unless it is decided that, beyond that moment of time, there is going to be no further expansion or change; that is a most unlikely situation.

This initial forecast is seldom a simple thing to do. Anyone who has had to face it in even the most predictable of operations is well aware that he has to rely on "intelligent guessing" for some of the factors. In the National Health Service, there are more of these factors than in any other situation which I, personally, have experienced in quite a long industrial career.

We are fortunate enough to have had, within the last few months, the report of the Royal Commission on Medical Education, and their Chapter 6 headed "The Number of Medical School Places Required" is of tremendous interest to us from a number of points of view.

I cannot refrain from telling you that the introduction to this chapter made me smile to myself. Part of it reads: "Manpower needs and their implications for the output of doctors from British medical schools are not specifically mentioned in our terms of reference; we were, nevertheless, enjoined to consider among other things what changes may be needed in the number of medical schools in Great Britain. Moreover, the scale of the provision required is fundamental to a consideration of the form and pattern of medical education." I smiled to myself because I concluded, rightly or wrongly, that they had reached the point in their deliberations where they could no longer avoid this frightening question as to what provision they should make for the new things to come. I would have given a great deal to have heard their discussions at this point.

The conclusion to which the Royal Commission came was, presumably, that the question is unanswerable; they admitted that their final conclusions included no adequate allowance for the rising standard of medical service which is invariably demanded as living standards generally are improved, nor for any decrease in working hours to meet the needs of study and relaxation. If I may select one figure from their table,¹ I will take the 78,100 "economically active"

¹ Reproduced at the end of this paper.

doctors which is given as being the requirement for 1975. They took the comparable figure for 1965 as 62,700, so they are proposing an average increase of 2.5% over the ten years from 1965 to 1975. Currently this figure is about 1½%.

I believe that the Royal Commission were right to omit the question of the standard of the future medical service. The increase which they suggested is in itself such a tremendous task that we shall do more than well if we achieve it; that being so, there seems to be nothing to be gained by adding more for a mere guess. They carried this argument through to 1984, by which time this total figure for "economically active" doctors is 96,400, and that calls for a final annual entry to the medical schools in that year of 5,000 against the current 2,600. They say that this increase "is both necessary, if a satisfactory number of doctors is to be provided in this period, and practical in terms of the number of able students who will be available."

I would like to return to this quotation from the Royal Commission's Report but I will leave it for the moment, merely repeating the comment that we are fortunate to have had the benefit of their work to help us; they have at least given us a target. So far as the nurses are concerned, we have got no such assistance. In recent months there has been a report from the National Board for Prices and Incomes on the pay of nurses and midwives in the National Health Service: it was not part of the Board's task to do for the nurses what the Royal Commission did for the doctors, and so we have not got the advantage of their deliberations on a final target for the future. As far as I know, no one has ever attempted this task, although the profession must have been subjected to more enquiries and studies than any two others put together. On the other hand, the Board has given us some valuable advice about the deployment of nurses. Mr. Aubrey Jones will, I hope, forgive me if I confess to a feeling that his paragraph 156 is in danger of being rather more comforting than he and his colleagues intended. Judging from common gossip, the sentence "we did not find evidence of a general shortage affecting every grade and every type of hospital" may well have surprised people more knowledgeable than myself, but it must be read in close conjunction with the supporting paragraphs.

We are in a similar predicament so far as the ancillary services are concerned; we have no forecasts. It would make a nice tidy picture if we could attach to our target of 78,100 doctors a related set of figures for the nurses, the ancillary services and the administrative staff, but that is not possible at this moment of time and I feel we are not ready to attempt it even if we felt that such a set of figures would help us. There are a number of matters relating to management and its use of manpower which call for attention before we can think of such things as an ideal or firm establishment. Much work has already been done in various fields and the day may come when we find we really can attempt to do this. I think the only assumption we can make at the moment is that the development of the National Health Service must involve an all-round increase in the demands for manpower if we are to support the increased intake of doctors: let us make that assumption without attempting to give ourselves specific targets. The truth is that we have got no alternative, and if we are convinced the Service is going to continue to expand, which surely it must, we need have no fear of recruiting more people than those for whom a satisfactory career can be offered. This mistake, I am told, was made once before. I doubt if there has ever been trouble of that kind in an organisation with expansion of the kind we envisage. Once more, it is the resources, human and material, which will determine the size of the recruiting programme.

In other and more simple circumstances, a manpower policy is, as has been said, started by making a forecast—by quantity and qualifications—of the numbers required to achieve an agreed level of service by a certain date. We have at least part of this so far as the doctors are concerned but as yet for no one else. The second stage is to set against these figures the estimated strength at the same date from the men and women already in the Service, making due allowance for wastage of various kinds. Again, we have this built into the Royal Commission's report but for nobody else. The third stage, to which I wish to invite your attention, is the task of ensuring that we make full and proper use of our staff.

As this is the part of my paper which I hope will be most productive of constructive discussion, I want to preface it with one or two points which have given me much food for thought.

The Royal Commission's Report has told us, in round figures, that we must redouble our efforts to attract entrants into the medical profession despite the fact that these efforts in the last ten years or so have been on no mean scale. They tell us that the target which they have suggested, and I quote the sentence again, "is practical in terms of the able students who will be available". The statement is supported by convincing figures which show that when the intake of the medical schools reaches its peak, the percentage which they will be taking of the total numbers qualifying to enter the universities will fall to 3.7% which is where it stands today (it rises to about 4.5% during the seventies).

The argument relies, therefore, on the figures from Lord Robbins' Committee on Higher Education in which it is envisaged that the intake of the universities in the years 1980-1984 will reach 453,000 which is only 13,000 below doubling the total for the current five-year period. The Robbins Committee was, obviously, a distinguished and learned body which, having examined the question thoroughly, went on record as being convinced that even such an enormous expansion of higher education would not fail as a result of shortage of students with sufficient intelligence. I am not courageous enough to say more than that I am apprehensive.

I am apprehensive for other reasons, too. Our increases of manpower must come from the young people as they finish their secondary education and their numbers are currently falling. In the ten years from 1965 the expected decline of 18-year-olds is over 15%, thereafter the figures should rise again but will not pass the 1965 level until after 1980.

Then there are two aspects of competition for manpower to be borne in mind. May I draw your attention to them?

First, I said earlier that the Health and Welfare Services took 4.6% of the Gross National Product in 1966. In the same year Education took 5.7%, Housing 2.8%, Roads 1.4%, and Defence 6.8%. I suppose all of us share a hope that it will be possible to reduce the figure for Defence, but we must recognise that the Ministers responsible for each and every one of those spending departments will be competing strongly and convincingly for an increase in his share.

Second, in 1964, 25% of the working population was employed in the public sector and, more significantly, this included 60% of the men and women who had enjoyed a full higher education. Since that year, both those figures have increased. I will not pretend that the two terms "public sector" and the "spending section" of our society define exactly the same groups, but it is not unreasonable so to regard them in making my point: the "private sector" might, in these circumstances, be termed the "wealth creators". I am not in the least

interested in the question of public and private ownership, but I am concerned by the fact that the proportion of higher educated people going to the "wealth creators" might be getting dangerously low. If that is so, the competition from that group for able recruits will be stronger than ever before. Do not let us forget that the maintenance and, indeed, an increase in their efficiency is vital to us all.

I have admitted to some feelings of apprehension but, let me hasten to add, only because so many difficulties are in the way of achieving our recruiting goals that I feel we shall have to be fortunate as well as skilful to reach them. On the other hand, I am convinced that there is much that we can, and must, do to prepare for that possibility. If I am wrong in my pessimism, and I hope I am, then we shall be that much better off. The thing which we must do is improve our management.

I hope that none of the people concerned in the management of the National Health Service will take offence at this contention. In my relatively short experience of the Service, I have learned to admire their work more and more, so I will add that I am convinced that the same comment could be made of any operation in industry or anywhere else, because the task of improvement in making full economic use of all resources—men, women, and equipment—is a never-ending one. At the same time, it must be admitted that the National Health Service was not one of those which took the lead in training its management and it has much leeway to make up. The advent of the National Staff Committee has, in my view, made a splendid start in this regard. But I must be more specific.

So far as the doctors are concerned, I need do no more than draw attention to the Chief Medical Officer's admirable letter of 15th February 1968, headed "New developments and the redeployment of resources". This letter is so much to the point that I was tempted to give it in full, but I will content myself with two short extracts. It reads "We can only get the best collective result if all are prepared to look coolly and critically at many traditional practices in which modification may be possible" and "I am therefore writing to ask your help in a drive to free staff or resources which are not at present being used to the best advantage for redeployment elsewhere".

It is the thought behind this letter which I hope to leave uppermost in your mind. So far as the nurses are concerned, both the Salmon Report and Report No. 60 of the National Board for Prices and Incomes are pointing in the same direction—redeployment of skilled people so that we do not waste the priceless resources of their knowledge and training. The people concerned with nursing research at the Ministry have done a great deal of work in this field—work on the use of ward clerks, ward housekeepers and auxiliaries, and also in the field of centralising supplies. As new medical techniques are developed so the skill of specialised nursing grows in value, the full economic use of that skill is vital and is a management task.

Then there is the whole area of buildings and equipment. Projects for new buildings or alterations to existing buildings must always have the aspect of economy of labour carefully examined and one hopes that whenever they show a saving in this direction they will go higher in the list of priorities; the same goes for equipment.

In any or all of these areas there may well be scope for the trained advice of the Work Study Officer. Work Study Officers are no longer new in the National Health Service and from my limited experience they seem to be highly capable

people; but I cannot help wondering if they are given the standing which they need and justify. Industry has learned by bitter experience that the job, which calls for infinite tact as well as professional skill, must have wholehearted backing from the top; this is essential. Once this is clearly understood by everyone concerned, it is possible to get the intelligent and active support of all those who are involved in the department or operation which is being studied; this is the next essential, and it does mean everyone, not only the heads of departments. Frequently, it includes people outside the department, for instance, if and when trade unions are involved they should be brought in as partners at an early stage. In other words, communications are vital; when people understand what is being done and have the opportunity to contribute towards final decisions, progress really can be achieved.

I have a strong suspicion that there is a host of activities where time and labour can be saved in hospitals. How is it, for example, that Hospital A is discharging its in-patients two days earlier than Hospital B, or Hospital C has a bed occupancy which is 3% higher than Hospital D? How is it that, in a group of a dozen hospitals of roughly the same size and kind, the cost of, say, medical records differs so widely? It cannot be, surely, that it is merely a different way of keeping the books. If it is, then the book-keeping needs investigation somewhere. There are many more examples of this kind which could be quoted, as you all know.

The basis for improvement in management is a sound personal policy. Entrants into the Service, be they doctors, nurses, technicians, administrators or what you will, must be attracted by the knowledge that they are going to be properly trained, that their pay and conditions of service are going to be fair, and that there will be opportunities for progressing as far as their ability and enthusiasm will permit. We must ask ourselves whether we can be regarded as a good employer. This is no place to go into these matters in detail, but there are one or two observations which I cannot resist.

The material rewards for those who enter any form of government service will always be less than for those who choose the greater risks elsewhere; but, thank heaven, material rewards alone do not provide the full satisfaction of a career, so I do not anticipate any serious threat on that score so long as we can be sure that levels of remuneration are kept up to a reasonably comparable rate. The danger is obvious; all people paid by the Treasury, who are the custodians of the public purse, are obliged to adhere to any restraints which may be the policy of the day more strictly than anyone else: I am thinking particularly of clerical and works staff—and porters and cooks, and the like, and the younger age groups. As many of us in London know only too well—I have not much knowledge at the moment outside London—we in London, are in serious difficulties and I dread to think of the money we are wasting on advertising to try and fill and only partially fill, the vacancies which exist. We must look at such things as pension arrangements. Are they reasonably competitive? Is it right, for instance, for a Matron's pension to be based on her salary where, rightly or wrongly, a substantial part of her remuneration is virtually in kind? I have also the feeling that we have allowed the Whitley machinery to become overcomplicated. I strongly believe in the principle of the Whitley Councils, but I would dearly love to see if we can simplify their method of work. I was told last night by a prominent member of the Whitley Council machinery that they have to deal with 54 different negotiating bodies. I was able in reply to put up a rather weak 26 at one factory with which I have been concerned up till last

March, but we were able to do the basic negotiating with all 26 in one place and at the same time. I wonder if we can find any improvement down that sort of road? I believe that in our anxiety to do justice we make things pretty difficult for ourselves and perhaps more difficult than they need be. At the present moment, for example, in a Teaching Hospital, we can even have our throats cut by our cousins in the Medical schools where they are often able to offer better terms for similar jobs. I have said "cousins" and not "brothers" because we have not got the same father.

I am disappointed to see the Prices and Incomes Board proposing to extend the overtime payment for nurses. Progressive industrial organisations are searching for agreements which cover extra hours worked without the extra and costly clerical labour involved in the recording and calculating: such agreements are being made.

Looking at another aspect of conditions of service, we must be prepared to spread some of our money on reasonable accommodation for doctors and other skilled people—and the same can be said in relation to part-time workers. Unless we give proper attention to this sort of thing, and others which I have mentioned, we cannot expect to get our share of the potential ability in professional skill and management. We will not be regarded as good enough employers.

Finally a word about joint consultation. Much nonsense used to be written and said on this subject and, we must admit it, neither the medical nor nursing professions have been leaders in adopting it. Perhaps this is a point at which I might usefully comment on some suggestions which, not for the first time, I have seen in the press recently. The main theme of these suggestions is that the Hospital Service is on the verge of moving towards the introduction of general managers with authority over medical and nursing directors. This very idea was put to me by a member of my Board of Governors on seeing the hospital organisation for the first time and comparing it with the industrial organisation of his experience. I pointed out in reply to him that there was one big difference which was that the top of the industrial ladder was open to competition from all sides of the organisation and the chairman or managing director or whatever he is could have reached that position from the production side, or the marketing, or the accounting, or what you will. It was clearly the senior position in the organisation, probably the highest paid, and open to anyone with the requisite experience, ability, and skill. This is not so in the Hospital Service, because the senior administrative job is not clearly the senior position in the hospital. But even if it could be made so attractive as to be the final goal of, say, a leading consultant (who would then cease to function as a medical man), the occupant would still be in no position to dictate to the medical, nursing and other disciplines which are to be found in a hospital and whose decisions must depend to so large an extent on questions of clinical or other professional judgments.

I do not see the managing director in the National Health Service for many years—if at all, but even supposing the top administrative job were clearly the senior and most attractive position in the line of hospital management, need the medical or other professions really be quite so concerned? No managing director worth his salt attempts to tell his experts how to do their jobs—he leads the team which decides on what ought to be done and leaves the experts to do it, to manage his own affairs and manage his own department. The important words here are that he "leads the team". In other words, he consults with those

experts and this is where intelligent joint consultation starts. It is based on the belief that management will make better decisions if everyone concerned is given the opportunity to contribute from his or her experience or skill to the making of that decision. Out of this approach to the task is good management born and out of better management will this great Service go forward into the future.

I personally have the privilege of being Chairman of two important Boards. I regard a large part of my duty as being that of looking after the staff and seeing that they have satisfactory careers, working for a good employer. If I can succeed in that, I need not worry over much about the patients, because the staff will do that for me.

* * * *

Table¹
Doctors and Population in Great Britain, 1911-75^a

Year	Population (millions)	Number of Doctors "Economically Active"	Doctors for each million population
1911	40.83	26,700	654
1921	42.77	27,760	649
1931	44.80	33,390	745
1951	48.85	48,220	987
1955	49.55	53,260 ^b	1,075
1961	51.28	59,200 ^a	1,154
1965	53.10	62,700 ^b	1,181
1975	56.40 ^a	(a) 68,100 (b) 78,100	1,207 1,385

* * * *

Sir Stephen Lycett Green, Chairman of the East Anglian Regional Hospital Board, opening the discussion on Mr. Bonham-Carter's paper said that he thought it would be most useful to try to translate some of the things which had been said into terms of the impact of manpower requirements upon his Board. The Board hoped to complete three new district general hospitals by the end of the 1970s. Estimates prepared in 1965 had shown that these hospitals would require increases of staff of 40% for nursing, 37% for technical staff, 40% for junior medical and 17% for others over those already in post. It would be quite

¹ Taken from Chapter 6 of the Report of the Royal Commission on Medical Education 1965-1968 (Cmd. 3569).

^a Except where otherwise stated the figures are from Census reports of the "home population" and total number of doctors occupied (whole-time or part-time) in civilian practice. They may be taken to refer to the beginning of April. The estimates and projections relate to the middle of the year. To maintain conformity with the population projections, estimated numbers of doctors from 1965 onwards include those in practice in the armed forces, whether at home or overseas.

^b Estimate used by the Willink Committee.

^c From 10% sample Census, adjusted for bias.

^d Estimated by the Commission.

^e As projected by the Government Actuary's Department in consultation with the General Register Offices of England and Wales and of Scotland.

(a) Expected if medical school capacity increases as planned in mid-1966.

(b) Need assessed by the Commission.

unrealistic to assume that those additional people were going to be recruited from a comparatively sparsely populated region like East Anglia, although it was a region where the population was increasing. They would, therefore, have to draw them from the general pool of labour in other parts of the country which would be available at the end of the 1970s.

So far as nurses were concerned it was generally accepted that young women were marrying, having children and leaving employment very much earlier than ever before, although some did return to work in early middle-age when the children were older. Those tendencies were reflected in the Ministry of Labour's forecast that there would be a comparatively small increase in the total number of employed women in the 1980s over the 1965 total, that the number of unattached women in employment would fall, particularly in the age group 15 to 44, and that the situation would only be remedied by an increase in the number of married women in employment. The latter group were not a very satisfactory basis upon which to staff hospitals.

Further, there was about to be built at Bury St. Edmunds one of two "best-buy" hospitals. They were based upon a standard of bed provision substantially below that which had been laid down in the Hospital Plan. As a result, those hospitals would be able to function only if the local authority and general practitioner services were geared to receive the patients who would be much more rapidly discharged to their care than hitherto. This meant that the labour situation would be further aggravated in that the local authorities would also require more nurses, social workers, health visitors and home helps.

If there was not going to be a spectacular increase in the amount of labour available to meet the increase in demand for labour by the National Health Service, the only ways in which the gap could be filled were, as Mr. Bonham-Carter had indicated, by doing everything possible to increase the efficiency of the existing labour force and then by using it more effectively. He had mentioned work study. There was a suspicion that some members of hospital authorities paid only lip service to this theme. On the other hand, there were very few work studies which did not entail, for their successful implementation, an initial outlay of money to install new forms of equipment and there were few things more frustrating than for a Hospital Management Committee to propose to adopt a new scheme which might well save thousands of pounds only to be told that there could be no extra allocation to cover the initial outlay.

On the subject of salaries, it appeared that much more needed to be done to bring about a proper system of payment for work in the Service. The Whitley Council machinery should be looked at again to see in what ways it could be improved.

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In the discussion which followed, the point was frequently made that the desired staff levels were not going to be attained and strenuous efforts would need to be made to make more efficient use of staff already in post. If the potential demand for teachers were met it would take up the whole of the woman-power output of the schools over the next decade. Locally it was essential for the consultants and management to get together now to decide for each hospital or group how the beds could be used most effectively for the benefit of the patients. It was quite impossible to staff the many highly specialised units unless these were carefully spaced over the country. This was not just a task for the future in relation to the new hospitals but one to be tackled im-

mediately. Centrally also there was need to ensure a better geographical distribution of manpower resources.

There should be retraining schemes for married women returning to work and better pay and conditions to prevent the drift from the Service and to permit the Service to compete on better terms against the increasing demands from other professions and industries. Increased responsibility should be given to new entrants to take account of the higher standard of education of today's school-leavers. Greater urgency should be shown to the problem of replacing the nurse by auxiliaries, housekeeping teams and ward clerks on non-nursing duties and so increasing the job satisfaction for the nurses and reducing wastage. The possibility of increasing the outlets for voluntary workers—including the National Hospital Service Reserve—should also be explored.

One member said that patients were often admitted to hospital some days before treatment or examination began. This was wasteful of hospital resources and could often be wasteful to the community. Management should put its house in order and remember, too, that the general practitioner had a part to play in a hospital decision to discharge the patient so that home conditions could be taken into account.

Other members said that there must be a willingness on the part of everybody to receive new ideas with rather more readiness than they had in the past. There must be, too, at all levels a willingness to delegate responsibility so that each individual felt that he was challenged to use his powers of responsibility, discretion and decision-making to the maximum. A plea was made for management courses at all levels including the general practitioner. In considering manpower, quality had to be considered as well as quantity.

Reference was made to the staffing problems of the general practitioner. The tendency today was towards group practice and health centres and there was likely to be a shortage of nurses, health visitors, social workers and secretaries even more acute than the shortage of doctors.

There was a plea for more delegation of responsibility to the professions supplementary to medicine so as to eliminate a good deal of unconstructive work. A better understanding between the doctor and the physiotherapists could easily lead to the quicker treatment and discharge of patients.

When it came to make changes in the administrative structure of the Service, the Department ought to make sure that each area did not try to provide a full range of specialist units too small to be viable and that there should be some flexibility in the arrangements—what suited one part of the country was not necessarily right for another. Should there not be some experimentation in advance?

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Mr. Bonham-Carter replied to the discussion and said that the manpower shortage, to which so many speakers had referred, was something which had to be faced by them all, not just at Ministry level, to see how it was going to affect their future plans.

He was glad that the subject of communications had been referred to repeatedly throughout the Conference. So often it was the answer to problems which arose throughout the Service. He did not propose to enter into the discussion, however, because it was the subject of a later session.

In reply to a specific question which he had been asked, Mr. Bonham-Carter said that he thought the value of personnel officers and personnel departments

was now proven. When they had first started on the National Staff Committee he had quite early on preached the value of the personnel officer and he believed that the decision to introduce regional staff officers into the Service had already shown good results. He was confident that they were going to make an increasing contribution to the future. He was a strong believer in personnel officers in the larger hospitals, but this did not mean that he was advocating their appointment all over the country in the very small groups. He thought this was a matter for local judgment.

Session 4, Part II Manning the Service

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I am particularly glad to have been invited to take part in this Conference, for a number of reasons. The first of them is that I well recollect a similar conference held in this very hall about twenty years ago, or shortly after that, not under the auspices of the Ministry of Health at that time but under the auspices of the Royal Institute of Public Administration. I remember coming to that conference as, obviously, a much younger and notably slimmer, but, I hope, no less enthusiastic and optimistic individual to enter into the discussion. One of the people giving the paper was to say something on the subject of medical administration, which I thought at that time particularly needed to be criticised, so I participated from the floor on that occasion. At that time, we were looking forward to what was going to happen in what was then an infant service. We were talking about structure and administration and many other matters, but we were certainly not talking about manpower utilisation, work study, management techniques, training and the subjects with which we are concerned today. It is a measure of the way in which the Service has developed that these have now become the topics of today. We did not even start to think about training in the Service until six or seven years after that conference, and when we did start it was in a rather hesitant way. Now it becomes a centrepiece of our deliberations and is a very important subject with us.

One thing that has happened since that other conference in this hall is that the Service has been a success story. But people still grouse about it. People in it—to use an expression by one more famous than I, who lives not very far from here—sometimes tend to sell it short. Those associated with it do not always do it justice. Nevertheless, its record—and statistics have been before this Conference—is a very notable one indeed. We can and shall improve on it. One of the things this Conference is about is the way in which improvement will come about.

In looking back to the former conference, and having been associated in some way with the Service throughout the intervening years, I want to start on the note that we are building on foundations which, on the whole, have been well laid. I want to start also by dealing with three general propositions about staffing in this Service. To some extent they repeat things that have been said at this Conference, but I think they bear saying again and perhaps with a slightly different emphasis because of my somewhat different approach to them.

The first of them is that the National Health Service calls upon a great multiplicity of professional skills and occupations. Some of these we share with other fields of activity. This goes for many of the professions and skills represented in the Service, including accountants, engineers, architects, cooks, technicians and a great many other staff. Also, we have the people who are to be found mostly in the Health Service itself. In both cases, we are concerned with finding enough people of the right quality, providing adequate training facilities and, where there are categories of staff where we are in competition with other fields, of finding the right way to get them into the Service and to keep them there. This is not just a problem of recruitment. It is one of the retention of staff once you have got them in. This has been one of the greatest difficulties, and

involves immediately such considerations as job satisfaction, reasonable security, and good promotion prospects.

Somebody said yesterday that we had left it rather a long time before referring to job satisfaction. Perhaps we have. Certainly this is the right time to make something of this. I may have misheard the contributor to the discussion. I thought at one point it was said that money was not a primary consideration in job satisfaction. If in fact I did hear that, I must say I certainly cannot agree with it. It is only one of the elements, but unless you get the pay and the prospects and the career structure right, then one of the important elements of job satisfaction is missing.

I think also there is a need to realise in the Service, and make it realised outside the Service, just how complex our staff situation is. We have been talking earlier about television programmes, non-fictional, fictional, and indeed semi-fictional. One must say there is one common factor about all these, which is that with very few exceptions they portray a fascinating world which is exclusively occupied by nurses and doctors, in that order, and by an occasional patient who is sometimes put in the background as a bit of local colour. This is the picture I think we have to dispel. We have not only to dispel it outside the Service, we have to get our own minds clear about it. I think people in the Service very often tend to have blinkers on and tend not to recognise the very great contribution made by staff working in the same field, but not in their own particular section of it.

This brings me to the second general proposition, which is that team work and parity of esteem between all members of the team are essential elements in the success of any project in this Service. This does not only apply to much publicised surgical achievements—and in my view often over-publicised surgical achievements—it applies to everything that goes on in the hospital or health service field. There is nothing, of course, that is mundane as far as patients are concerned at the receiving end. In nearly every activity, a multiplicity of people play their part and I think each one should realise as fully as they can what the others are doing. It is a matter of communication, information, not just doing things but telling your colleagues you are doing things and telling them why you are doing them.

The Health Service and my own main field of activity are not blameless in this, and indeed almost every major field of activity suffers from people engaged in it knowing what they themselves are doing but not realising that they have to tell other people why they are doing it to get the fullest co-operation from them.

This proposition sounds a bit like a cliché. It is really not one, because I think there is too little appreciation of the contribution made by many skilled and qualified staff to the success of the medical and nursing function. One of the things now emerging as we dig more deeply into training is the need for interdisciplinary contacts and activities right across the board. It is not easy. We must not blind our eyes to the fact that there are vested interests, sectional jealousies and a good deal of defence mechanism in the many and varied fields of staffing in this Service. If we recognise that, perhaps we can do something about it.

The third and last of these preliminary propositions is that, as well as having a varied and complex staffing structure, this Service as a whole is just about the most difficult organisation in which to operate a staffing structure in a way which enables the best results to be obtained from the great input of human resources, talent and money that we have in the Service. We are divided into three major compartments by the 1946 Act. I do not particularly complain about

that. I think there was rhyme and reason for it and, as I said earlier, I do not think it has worked at all badly. The trouble is that in each of these compartments one has too many little worlds, too many people moving around in water-tight compartments. This makes the line of authority and responsibility very difficult to determine. Harry Truman, when President of the United States, had a card on his in-tray and on the card was written "The buck stops here". How many of you really know where the buck stops, particularly in the hospital service but also in other parts of the Health Service? Where does authority really lie, for example, in hospital management committee groups? I do not really know. I have lately been serving as a member of a Hospital Management Committee and getting a rather different insight into things. I can see a lot of people exercising partial authority; I cannot see anybody operating over the whole of the field. I just do not know where the buck rests in the Hospital Service. I hope in any reorganisation that emerges when we get this vividly Green Paper—as I hope it will still be after its fairly long period of gestation—we shall have a structure which will enable us to devise lines of responsibility and authority more clearly. I do not much care whether it is couched in terms of general management or whatever sort of expression. I just want to see the thing sorted out.

This brings me to the responsibility of staff interests in relation to the matters about which I am going to talk. One fact dominating all the others is that we are living in a time of very rapid change in the National Health Service. Again, an obvious statement. This has been the constant theme of this Conference, just as it is the constant preoccupation of hospital authorities, executive councils, local health authorities, and all other bodies which have the responsibility of providing health services.

This concern with change and acknowledgement of change is no less the concern of the trade unions and other organisations representing the interests of the staff who run the service, no less their concern than that of management in its various guises and aspects because, without the co-operation of staff at all levels and without their active participation in the taking of important decisions and the working out in practice of those decisions, it is just not possible to deal realistically with the problems of major change, involving as they do economy, efficiency, the fuller provision of services. (An example very much in my mind at present is the working out in practice of the Doctors' Charter and the enormous transformation this has caused in the executive council service and the enormous loyalty and co-operation it has called for from executive council staff.) The best use of skilled manpower over the whole field of changing working practices, new training methods and approaches and many other developments are also involved. There is not one of these in which the staff in the Service have not got a part to play, not just as functionaries but as the people who are helping shape the course of events and helping to co-operate in a positive way in bringing about change.

I think on the whole this role of staff interests is acknowledged, but I have to make the point that I do still occasionally detect signs of blind spots in high places. I do occasionally hear, to my horror, somebody say, "Must we really consult the Staff Side?" or "Is it really a matter for the Staff Side?" I think there are very few things that are not matters for the Staff Side in an evolving service of this kind. Therefore, the point has to be well and clearly made today; and certainly over this period of twenty years the Service, as I have seen it, has been at its least effective when this principle has been overlooked—and there have

been times when it has been overlooked and we have had some pretty grim passages in the working of these much-maligned Whitley Councils. Everybody says they are sacred cows and there is this, that and the other wrong with them; but nobody says what we should put in their place. Nobody tells me how we can get a civilised, democratic, constructive, confrontation of staff and management interests other than through machinery of this kind without getting into a state of chaos. It is not the machinery that is wrong, it is the way it has worked over the years, the number of times it has sent us to the Industrial Court to sort problems we ought to have been able to sort out, as we do more successfully now, in a spirit of conciliation and mutual understanding. I would not be party to rapping the Whitley Councils. I hope we shall go on learning, as we are learning, to make them more effective instruments not only in negotiations of pay and conditions, but on the important matter of the role and staff interests in securing the well-being of the Service.

The obligation on staff bodies to make an effective contribution in these matters does not only rest on their own sense of responsibility to their members and to the Service, although this is indeed a high sense of responsibility. It is also one of the duties they accept in participating in the work of the Whitley Councils. Let us look back again to the very beginning twenty years ago, when the main constitution for Health Service Whitley Councils was being worked out. We put in this very important function: "To secure the greatest possible measure of co-operation between the authorities responsible for the nation's health and the general body of persons engaged in the health services, with a view to increasing efficiency in the public service and the well-being of those engaged in the services". I think this has a prophetic note—more prophetic than those who were concerned at the time thought it was going to be when they worked out these objectives. It is significant, in the light of situations with which we are now concerned that efficiency and the well-being of the Service were linked in the objectives of the Whitley Councils as long as twenty years ago, because these things are now very closely linked in our negotiations and in the whole atmosphere in which we concern ourselves with management and staff relationships in this Service. We are now living in a period of Government incomes policy and growing Government intervention in the negotiation of pay and conditions, in the shaping of career structures, and indeed almost everything that happens in a given calling or occupation. This has led us to more sharply defined criteria to govern pay increases and the establishment of new machinery and processes to deal with problems arising from the pursuit of the productivity, prices and incomes policy which not only the present Government but previous Governments have steadily more and more involved themselves in. Incidentally, I do not think a change of Government, should an event of that kind happen within the next twenty years, would cause any fundamental change in policy because this is something that started way back certainly in a continuous form as far back as the Selwyn Lloyd pay pause in 1961, and has developed in momentum and, indeed, has been increasingly seen as a necessity in terms of the national economy and is likely to remain so well forward into the future. We shall not be returning to some mysterious era in which we shall not be dealing very closely with government policy when trying to look after staff interests and regulate staff/management relationships. We have criteria, and I will come to those in a moment. We also have a lot of new machinery.

Among the developments emerging from the pursuit of a productivity, prices and incomes policy has been the Prices and Incomes Board. A lot of people who

have not really studied its activities are damning the Board out of hand without stopping to think of the considerable potential for good it has in many of the matters important to us. So far, the Board has produced two reports which have had a major bearing on this Service. Report No. 29—and my friend, Alan Fisher, is I know going to say something about this later—made far-reaching proposals for the organisation of manual and ancillary manpower. It did not just concern itself with pay. It concerned itself with structure and with a whole new way of looking at things. More recently, we have had Report No. 60, which made recommendations involving changes in nursing practice and the management of the nursing work force. Some powerful interests say it should not have delved so deeply into these matters. I do not think you will find the Board is going to refrain in references to it from delving deeply into the background of many of the situations which cause such references. I think this piece of machinery will affect us in the Health Service a great deal in the future, as it has already started to do. I suppose the Board has a difficult task in sifting the evidence it receives and in reaching its conclusions. Of course, it is even more difficult for the Whitley Councils which get the end product of its deliberations to work out the practical applications of its conclusions. This is at present a problem with the nurses and, in his field, Alan Fisher and his colleagues are also wrestling with the problem of converting the Board's recommendations into positive action.

My object now is not to carry this part of the subject any further in detail, but to underline again the total involvement of staff interests in these matters. If a reference goes to the Board, they do not want one or two points of views they want every point of view. They seek these views formally and informally and sometimes in a fairly thorough-going way. Staff organisations here have the full opportunity of presenting their point of view.

Apart from the machinery, the other great change that has come about as a result of the pursuit of an incomes policy has been the definition of criteria for pay increases and other improvements. If you think this is straying a bit from the subject, I assure you it is very relevant to it indeed. Let me just read out some of the criteria from the White Paper "Productivity, Prices and Incomes Policy in 1968 and 1969" which provide the basis for pay negotiations—considerations we cannot get far away from in such negotiations—but which also go very, very much further in this matter of linking efficiency, the consequences of change, and so on, with the way in which we utilise manpower in our Service:

"(i) where the employees concerned, for example by accepting more exacting work or a major change in working practices, make a direct contribution towards increasing productivity in the particular firm or industry. Even in such cases some of the benefit should accrue to the community as a whole in the form of lower prices."

I want to read an implied term into this criterion so that it makes sense in terms of the requirements of a public, non-profit making Service. After "lower prices" we must add "or in better service to the community" because that is the way we interpret lower prices when we are operating a consumer service of this kind.

"(ii) Pay increases ~~can~~ be justified where it is essential in the national interest to secure change in the distribution of manpower (or to prevent a change which would otherwise take place)."

There are two others, but I am not going to weary you with them. The first two are the really important ones. They have a most important bearing on our subject today. They link financial recognition with manpower utilisation and

they call therefore for the most serious thought on the part of all concerned with the better functioning of this Service. If it is accepted, and it must be, because successive Ministry of Health reports tell us this and all the statistics quoted at this Conference have also told us, that the Service is increasing in output and results, and if at the same time we recognise that quantification of productivity in terms understood in the manufacturing process is impossible in many parts of the Service and difficult in others, then emphasis under the first criterion in linking job satisfaction, pay, results and so on with greater efficiency must be placed fairly and squarely upon acceptance of changes in working practice which make a direct contribution towards the provision of a more efficient service to the community. I have to tell my members, and some of my colleagues here today have to tell their members, that it is no use going to Whitley Councils crying out about the cost of living or various other factors which were very good pegs on which to hang arguments in the old days unless you can also answer for your contribution in the light of criterion No. (i). This is not difficult to do. Apart from the statistics showing increased efficiency, we can point to many recent developments involving changes in working practices and attitudes, such as new commitments to staff development and training, which provide the background of much of what we have been discussing.

We have been a long time getting round to adaptation to part-time work. Only last year in my Whitley Council we made an agreement to regulate it, though it is a situation that has been growing on us for some time. It is necessary to have flexibility and adjustment to accommodate this great working force of married women coming back into the Service, to which reference has been made earlier. All this, together with other things I shall refer to, points to the enormous area of change in which staff co-operation is necessary and must be acknowledged in more ways than one.

I cannot discuss in detail the many new and changing situations in which Health Service staff are involved. I want to refer to one or two major developments. I will mention first the Hospital Plan. We still have it. Perhaps it does not look quite like it did when it started, but the working out of its consequences is still a major factor in change. We have a new emphasis on the rationalisation of hospital services within the regions and within the groups; the revolution in general practice to which I have already referred; the introduction of computers and revised methods of working, including shift working in many situations and with many people who never thought they would have to deal with such a situation; work study; job evaluation; more intensive training in all sections of the Service; and attempts to establish a degree of mobility of staff in a Service where this is very difficult because it is not quite a national service and yet also not really a local service. All this makes an ambitious project like planned movement in the administrative and clerical field, to take an outstanding example, something very difficult to achieve.

This brings me to the reference Mr. Bonham-Carter has made to the work of the National Staff Committee and the Regional Staff Committees in the administrative and clerical field. These bodies have been concerning themselves with individual staff training, career planning, recruitment and promotion, and in general making the best use of manpower. They have been doing this to an extent never previously attempted in this Service. They have established very close consultative links with the staff side both nationally and in the regions. I want to say how in turn the Ministry of Health has been exemplary in the thorough processes of consultation—I say this advisedly—to which it has sub-

mitted reports and recommendations of the National Staff Committee before putting them into operation. I hope this deserved accolade will not be regarded as having been insincere in the light of something I am going to say in a moment. Consultation has been very good indeed.

But administrative and clerical staffing are only part of the picture. There are quite a lot of other fields in which important developments are taking place. We now have the National Nursing Staff Committee, set up after Salmon, and a host of other bodies, both official and unofficial, concerned with the training and staff development of other groups, including ancillary staff, executive council staff, and many of the professional and technical officers who play so important a role in the Service. And in the future hang the consequences of the Zuckerman Committee and I suppose in another field the Seehohm Committee, and goodness knows waiting for Seehohm has been one of the major activities of the last two or three years and a major exercise in patience. We also have the final deliberations of the Joint Working Party on the Organisation of Medical Work in Hospitals. Its first report has already said that "the pattern of training needs more detailed examination" and "a common basis of training for administrators in any branch of the Health Service could be devised". Yet again we have another field of exploration covered by the Noel Hall Committee on Pharmacists and Pharmacy Technicians. A lot of people and a lot of different bodies and committees are concerned with training and staff development of some kind and all in the same Service. There is bound to be a lot of overlapping. This makes me feel the time has come for consideration of the establishment of a body on the lines of an Industrial Training Board to deal with training problems as a whole in this Service. Local government, which has a similarly varied bag of problems, has now successfully established such a Board and I think what has been done there will repay study here. Whitley Council organisations would like something on these lines because the Industrial Training Board gives us something we have not got, something in fact which we were refused at the outset of national and regional staff committee work in the Health Service, which is direct participation by staff organisations.

I have said I have nothing but praise for the way in which we have had consultation, but consultation alone is not enough. The situation has developed to the point now where we want active participation of staff interests in the making of decisions and not just consultation on them. This is possible with the Training Board type of organisation. In Local Government there are thirteen trade union representatives out of a total of thirty members. This seems to me to be a reasonable balance. I think obviously there is a lot of co-ordination to be done. I think one can only get a properly skilled, professional training force if one has mechanism of the Training Board type. I hope this is something we shall now consider seriously.

I hope that what I have said will have reflected the very deep interest the staff side bodies have in this important subject of manning the Service. We have increasingly good buildings. We have good equipment, good physical stock in trade in many respects. But I think it will be common ground between us all that it is our human assets which in the end will determine success or failure of our endeavours in this Service. When I speak of human assets I do not just mean the recruitment, training and advancement or wastage, as the case may be, of so many male and female bodies. I mean no less the encouragement of the human spirit which should be an important feature of planning everywhere, and particularly in a Service like ours. It is not always finance which causes staff side

organisations to worry so much about individual cases as well as about negotiations for whole classes of people. It is this matter of the human spirit which makes us so concerned when the less fortunate seem to be getting a poorish deal in relation to the high-fliers, because we have to keep a fair balance between all types of staff.

This brings me to an important subject, and one I feel very strongly about as I know many of my colleagues in staff organisations do also. It is the protection of salaries and conditions of service when a man or woman has to take a step downwards, has to accept an inevitable loss of status because of some major development in the interests of the Service, be it regrouping or some other form of re-organisation. We are much more civilised about this than we used to be. We have got good agreements in the Whitley Councils now which recognise that if you cannot protect everything at least you can make a man feel that if he has been sacrificed in career terms for the good of the Service he is worth no less to that Service, and therefore we now have agreements which protect salaries and conditions of service. Unfortunately, there are still a few people who have not obtained that protection because they suffered their downgrading before the new agreement came into operation. They are very few in number. They have had an airing in the House of Commons recently and the Parliamentary Secretary dealt very adequately, but from my point of view not satisfactorily, with them. Mr. Minister, this is an anniversary. One gives presents on anniversaries! There are a couple of dozen people, no more than that, to whom I think you could bring a lot of job satisfaction and from whom you could get a much better job for the remainder of their time in this Service if you could change your mind on this important human problem.

In this address I have tried to bring out the points I think are important from the staff side point of view at this twentieth anniversary point in the history of the Health Service. I have tried to indicate where some future developments may lie and have tried to show some factors which have an important influence on those developments. I expect there will be surprises and disappointments in the next two decades, as there have been in the two we have now completed. It would be foolish to think there would not be. I at least hope that if and when they come they will not be attributable to the failure of management to consult speedily and effectively all the way down the line with staff interests, and that staff interests in their turn will be ready at all times both to respond to such consultations and also to take their own initiatives to participate fully when what is at stake is the well-being of the Service and those it serves throughout the community, as well as those who work in it.

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Discussion on Mr. Drain's paper was introduced by the following paper given by Mr. A. W. Fisher (National Union of Public Employees).

My colleague, Geoffrey Drain, began his examination of staffing considerations by emphasising the need to ensure that the Health Service received a fair share of available resources. I think this is a proposition that would meet with general approval. It is when we come, however, to look at precise terms and attempt to determine just how available the resources are in the light of competing claims from other sections and overall economic considerations that we run into difficulties. If the experience of the last twenty years has taught us nothing else, it has demonstrated that these difficulties of precise definition make long-term, forward-planning an extremely hazardous undertaking in the National

Health Service. With the painful experience of those twenty years very sharply in mind, I would be extremely reluctant even to attempt to forecast the pattern of the Service in twenty years' time. Much will depend on the events during the next two or three years. If we can establish a positive trend in the Service during that time, I will be much more optimistic about the prospect for the following seventeen or eighteen years.

From this, it follows that my major concern is with the immediate short-term planning rather than with long-range forecasting. Whilst not denying the need to secure a fair share of available resources for the Health Service, I am convinced that our current concern should be to secure the maximum use of existing resources. There are two advantages in this approach: the first, by concentrating our efforts on getting the best from what we already have, we will be able to secure partial insulation from the uncertainty which at present surrounds the economy generally; secondly, by subjecting the Service to the critical scrutiny which this approach demands, we will be establishing a firm base for future progress should the economic situation improve sufficiently to permit an increased allocation of resources to the Service. In such a short-term project, there is no doubt priority must be given to manpower planning. The Health Service is a labour intensive industry. Annual labour costs in the Hospital Service are more than six times the capital expenditure and account for some 70% of total revenue expenditure. Confronted with this relationship, any exercise designed to secure the maximum use of resources must concentrate its efforts on measures to secure the efficient use of manpower.

The immediate question posed by short-term planning considerations, therefore, becomes what must be done to secure maximum manpower utilisation. All of us involved in the Health Service have our personal response to this question. It is largely emotive and depends on our position in the hierarchy of the Service. Such responses are of little value in meeting the complex problems with which we are now confronted. We need the views of independent observers based on objective surveys. A comprehensive examination of this kind has not, unfortunately, been undertaken but we have been assisted by the two reports of the National Board for Prices and Incomes.

Report No. 29, on manual workers in the Health Services, Local Government, Water and Gas Supply, and Report No. 60, dealing with Nursing and Midwifery Staffs have been published. Report No. 29 is primarily concerned with ancillary staff, but its general observations on the Hospital Service have very much wider implications which merit careful consideration by all those who are concerned with the future of the Service. The report notes, for example, that financial control in hospitals is primarily directed to keeping within budgets rather than to reducing unit costs and that there are major deficiencies in organisation and the use of modern labour management techniques. One organisational difficulty arises from the need to secure balance between the requirements of administrative, nursing and medical branches. The Prices and Incomes Board discovered that success in securing this balance and in delegating authority varied considerably from hospital to hospital. Where this balance was not achieved, conflicts of authority were frequently discovered and even where it was achieved there was still occasional conflict between departments within one of the three branches.

An immediate need and prerequisite to many subsequent improvements was a higher level of managerial efficiency within the Hospital Service. The Prices and Incomes Board suggested that this could be more easily achieved if in-

dividual Management Committees were to be made responsible for greater numbers of hospitals, in order to provide an adequate base for a full range of management services. The Board noted that such a reorganisation would not only make it easier to secure manpower savings in the manual field through integrating activities and mechanising plant but would also have implications for the medical and nursing services.

Those who have read Report No. 60 on the nursing services will have seen the further references that the Board has made to the possibilities that they feel can arise through a general raising of the level of efficiency in all groups of staff employed in the Service.

Finally, the Board emphasised that there was considerable scope for the introduction of work study in the Hospital Service. As I have said, the Board was mainly concerned with ancillary staff, but work study applications are not limited to manual tasks and this observation by the Board has implications for a much wider range of staff.

The Board's report has met with a ready response from the trade union side of the Ancillary Staffs' Council. I must confess that our motives are not altogether altruistic. We see in the report an opportunity to improve our members' earnings through the effective organisation and utilisation of their working potential. Because of this, we have been able to take the initiative in efforts to secure the speedy implementation of the Board's recommendations, but there is a limit to what we can do. The major responsibility rests fairly and squarely with management and particularly with management at local level.

In the sixteen months since the publication of Report No. 29, the Ancillary Staffs' Council has made considerable progress on the introduction of work study in the Hospital Service, but these efforts will remain paper promises unless they are followed by action at hospital level. For example, the way is now clear for hospital authorities to call in the services of specialist work study officers and such action will bring quick and impressive returns. It is probably the best investment that hospitals can make and one which will pave the way for thorough investigation into manpower problems.

I might add here that my own Union is not unaware of the possible difficulties arising from the use of work study techniques and in fact recently appointed its own full-time work study officer.

Closely linked with the introduction of work study, the Ancillary Staffs' Council are at the point of making an agreement dealing with the introduction of incentive payment schemes and productivity agreements. We are hoping that within a matter of weeks we shall be able to send out to hospitals a paper setting out the framework within which they can formulate constructive and suitable incentive bonus schemes for all types of ancillary staffs.

There are a lot of people in the Hospital Service who doubt the practicability of incentive bonus schemes, believing them to be an innovation suited to productive industry. To them I would point to the evidence contained in Report No. 29 of the Prices and Incomes Board, where the Board told us that in Local Government, where the same view has prevailed for many years, the authorities have in fact now found that where schemes have been introduced it is possible after meeting all the costs of their introduction to save between £100 and £300 per worker per annum, as well as being able to pay the workers concerned substantially more money. If similar savings could be made in the Hospital Service, where 250,000 ancillary staff are employed, there is a potential saving of a minimum of £25 m., quite apart from the better use of hospital resources,

the higher standard of service and the higher wages for the staff which would result.

I believe the introduction of incentive schemes and use of work study are immediate and worthwhile objectives and that they should be enthusiastically supported by all those concerned with running the Hospital Service.

An argument I have heard put forward, particularly by those engaged in hospital administration and management, is that whilst what is said in Report No. 29 is true it does not apply to them. I would say to these people that we have had an interesting study carried out for the Ancillary Staffs' Council by the Economist Intelligence Unit into the utilisation of manpower in ancillary grades in a selected number of hospitals in this country. This was done by using a technique known as activity sampling and the observations made proved that there were a large number of workers who were not effectively occupied during a significant proportion of their working week.

There is also in the Hospital Service the problem of flexibility in the use of manpower and if we are to make the best use of our resources we have got to look at this, too.

Geoffrey Drain made a particular point about the need for a Training Board for the whole of the staff in the National Health Service and I fully support that. If we had an Industrial Training Board for the ancillary grades in the Hospital Service we would be raising and spending over a million pounds a year on training ancillary staff. Nothing like that sum is being spent in the National Health Service today and much more needs to be done. I know that the question of where the money is to come from is always a problem in the Health Service and unless a separate allocation of money is made available for training, which would be the case if we had a Training Board, we are not going to get the quality and quantity of training that is needed.

All the developments I have referred to and those which are, I am sure, to follow, raise sharply the need for a much wider participation by workers and by their unions in the management of the Service. In the past the issue of industrial democracy has been put in philosophical terms. Today, it has become an economic necessity. We cannot have training, the introduction of better methods, incentive payment schemes, job skills and job flexibility under close scrutiny unless we do it in co-operation with the workers concerned. It is impossible to envisage an effective exercise in manpower planning undertaken on the basis of a unilateral manpower management decision. From the start and throughout the exercise, workers and their unions must be actively involved. The maximum use of existing resources through the effective utilisation of manpower goes hand in hand with higher earnings and widening industrial democracy. It is what the trade unionist would call a package deal. I am convinced it is the kind of package that the Health Service needs on its twentieth birthday.

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In the general discussion which followed, one member said that, in his experience, it was not lack of money, as had been suggested earlier, which inhibited the implementation of work study reports—Boards ought to be able to help to find the small sums needed for essential equipment. The real problem, and this was reiterated by other members, was that hospital employees, supervisors and managers did not understand the value of work study, were not convinced of the need and, therefore, did not have the will to put a new scheme into

operation. Often the work study officers themselves had to implement schemes. Much more needed to be done to teach all levels of management about the value of work study. To this end work study should be included in all management courses, whether for nurses or for first line, middle or senior managers. There must be a move to a more effective use of staff through work and productivity measurement and supervisors must be made aware of such techniques so that they could put them into operation. There must be more discussion between managers and trade unions about the detailed operation of new schemes. Operational research was another tool of management. Again, schemes resulting from the use of this technique in, for example, maternity departments and stores organisation, had failed through lack of understanding of them, or of willingness to operate them, by people on the spot. Greater education of managers was needed if we were to achieve the enormous changes in hospital work loads which were possible.

Another member said that work study should not be confused with incentive payments or "measured day work" whereby the employee was allocated an amount of work and paid a negotiated rate on its completion. Nor must it be regarded as a panacea for all ailments although it certainly had a part to play in the struggle for increased efficiency. But there might be difficulty in recruiting enough work study engineers or finding sufficient savings to pay for them. It was not clear that sufficient consideration had been given to how many were, in fact, needed. Outside consultants might be called in to advise on the number of work study officers required, but great care needed to be taken because there were few good outside consultants in this field in this country. It should also be remembered that every single work study scheme had to be tailor-made for the individual hospital; there was no short cut to this.

The Whitley Council machinery was said by another speaker to be in need of overhaul. There were too many Councils and the individual Councils were too large. The relationships between the Whitley Councils, the professional bodies and the trade unions needed to be examined and the process of consultation speeded up. Professional bodies must rid themselves of their mistrust of the trade unions and recognise the professional expertise of the unions, while the unions must give up their claims to representation on professional bodies when their interest was only minimal. Technically the Ministry had no place in the Whitley Council machinery. This anomaly ought to be corrected.

Many staff training schemes were now in operation and some linked in with the polytechnics; but many more were needed and the creation of an Industrial Training Board was desirable. Many matters needed looking at, for example the number of hours physiotherapy teachers were expected to spend on teaching and the absence of Ministry recognition of the professionally approved qualifications for teachers of occupational therapy. Training schemes would not, however, alone achieve the objective of attracting more recruits to the Service and retaining them. There were people who really wanted to be physiotherapists, occupational therapists, remedial gymnasts, etc., rather than, say, school-teachers, and salary scales ought to be made more realistic in relation to qualifications and length of training.

Low salary scales (which sometimes led married men employed "full-time" at one hospital to work also part-time at another) and the burden of superannuation deductions were also referred to by a member who was concerned at the high and increasing proportion of women and part-time workers in the Service. He thought there could be no stability in the Service until there were

more men working full-time and the only way to achieve this was to make the pay scales more attractive.

Another member thought it was not recognised that administration today was a science in its own right, calling for training and experience, a knowledge of what goes on in other branches of the Service and, perhaps more important, what goes on in the minds of men. The administrator's job was to be knowledgeable not only of conditions and agreements but also of the frustrations felt by those working in the Service, and to be able to oil the machinery of the Service so that the professional could use his skills to the highest standard for the benefit of the patient. Legislation was placing heavy burdens on the administrator; there was also the tendency towards larger authorities, which was bound to be reflected in the Health Service organisation. All this pointed to the need for better salary scales and career prospects. It meant also, however, that the administrator had to widen his horizon, not merely geographically but also functionally so as to know what was going on in the Service as a whole. Patients had the right to look for efficiency, humanity and understanding in the Service and the administrators must act as public relations officers and ensure that they put over to the public the correct image of the Service so that confidence in it, so frequently an essential part of treatment, was established.

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Mr. Drain, replying to the discussion, said that he thought work study was only part of the whole process of change which had been under consideration. There might be a place for outside consultants but he agreed that their credentials needed careful examination. Work study consultants had themselves to be the subject of study before their usefulness could be established.

Several members had raised the point that it was essential to get everybody involved. It was not enough just to bring people in to do something. Everybody concerned must know the objective towards which they were working and this involved processes of communication and information.

There had been comment about the Whitley Councils themselves. While they had worked better in recent years, they could still be improved. The criticism of numbers and size was valid. The relationship to them of the professional bodies was a delicate matter; he understood their position in Whitley very well, having served with the Institute of Hospital Administrators and having been for the last ten years a trade union official with N.A.L.G.O. and serving on Whitley Councils. He could understand the concern of the professional bodies. He wished, however, that they would trust the trade unions a little more and enter into a relationship of the kind they had in local government, where there was a strong consultative bond between the professional bodies and the unions.

Women had a great part to play in the Health Service, but it would not be too good if it came to rely entirely or too greatly on part-time workers and on too great a preponderance of women workers. Terms and conditions of service could be made more attractive to full-time male workers. The fact of the matter was, though, that for the foreseeable future the Service would have to rely to a great extent on part-time staff, particularly women with family responsibilities, and would have to learn to accommodate working arrangements to suit these people.

In conclusion Mr. Drain said that while some of the proposals which had been made in the discussions on manpower were concerned more with the longer term future and would depend on the outcome of a good deal of research

and new developments, others were capable of accomplishment fairly quickly with little or no organisational structural changes. He expected that the two sessions on manpower would have together provided the foundation for immediate action on a number of important subjects which obviously caused concern to so many.

Session 5 Communications

Mr. G. McLachlan, C.B.E.,
Secretary, The Nuffield Provincial Hospitals Trust

I. The Complex Nature of the National Health Service

Twenty years since the "appointed day" for the bringing in of a unified, centrally-financed National Health Service is a very short time in the course of evolution of institutions: but the concept of a rationalised health service is neither exclusively British nor only twenty years old. The recognition of the sundering forces at work through specialisation in medicine, in the professions associated with medicine, and in allied social work, together with the need for the better use of resources, has been a spur for schemes of co-ordination and integration in many countries for a long time. In the United States with a pluralistic system of financing of health services, the emphasis at the moment is on the need for area-wide planning and Government sponsored Regional Medical Programmes of excellence. Students of comparative institutions will note that the National Health Service has formal provision for these key requirements in the planning functions of Regional Hospital Boards and the position of Teaching Hospitals.

The Nuffield Provincial Hospitals Trust, the body for which I work and which was set up nearly thirty years ago, has, as its first purpose, the co-ordination of hospital and associated medical services in the Provinces. It is relevant to the title of the paper that the trustees do not regard this objective as exactly out of date.

The National Health Service Act was, in one sense, a logical step in the United Kingdom, in containing some of the centrifugal forces at work in health services and in bringing them under some degree of control by means of an administrative framework which in effect covers a vast number of heterogeneous institutions, many of which, if not completely independent, have a fair degree of freedom of action. The effectiveness of all the participating institutions, in their objectives of providing a rational system of continuing medical care of high quality for patients, depends to a very large extent on a system of good "communications"; which is a word having a nice Twentieth Century, Mid-Atlantic ring, in one sense capsuling the present in its suggestion of something excitingly technical and scientific—in another, conjuring up human behaviour and so something metaphysical.

It is, therefore, I suppose, apt as the winding up subject for a conference on modern health services; for the great problem today, in a society that is becoming increasingly complex, is how to ensure the application of a wide range of scientific and technological achievements and a vast array of professional expertise and skill, to essentially human conditions.

Never before so urgently has there been a need for "imparting, conveying and exchange of ideas, knowledge, etc. . . ." which are the words by which the Shorter Oxford English Dictionary defines "communications".

This Conference has ranged over many aspects of health services: but it would be a pretence to claim that each of us feels that he has understood, far less been convinced by all the points of view expressed: no doubt an important objective will have been achieved if the papers presented and the discussions have helped us to sort out the bewilderment we sometimes feel about the range,

complexity and extent of some of the problems which beset the effective development of health services in Britain today. Such a congregation as we are is itself, of course, fundamentally a *means* of communication, and thus an important medium of introducing, discussing, and as a result, disseminating ideas; which, while the Prices and Incomes Board might find difficult to put a price tag on, are still the most valuable product of man's mind.

Yet, if we here find it difficult to communicate instantaneously the reasons for our several frustrations, and even more the solutions we all so earnestly crave, how much more so must the great mass of the people of this country who in one way or another, or at some time or another, will come into contact with some aspect of health services.

After all, we represent a very small proportion of the multitude of those who are directly concerned in one way or another with how health services are organised and made available to the population at large.

In contra-distinction to its cosy, easily delineated outline which makes it a first-class target, the National Health Service has a very complicated internal structure in which, to make its management more difficult, consultation has become the order of the day between many interests, individuals and groups, some of which are concerned with relatively narrow professional interests and some with genuinely held ideological beliefs of varying range and even consistency.

It is small wonder therefore that to meet the over-simplified requirements of the mass media, the various "Enquiries", "Insights" and "Spotlights" on the National Health Service tend to give a distorted picture of the whole.

The answer is not wholly better Public Relations exercises by the National Health Service, although these have their part. The disorder of which many of us complain in the public debates of certain major issues, are no more than the outward manifestation of the disorder of internal communications in the National Health Service. Too frequently we forget that any communication system has to have sufficient power to activate the distribution network: and if knowledge and understanding is the pre-requisite of power, we must look to the means of their generation within the National Health Service itself.

In First Corinthians, Chapter 15, we read that evil communications corrupt good manners; and while there are few occasions where communications are meant deliberately to mislead, or are delivered with malice, the effect of the combination of a bad communication network and the power failures which stem from a lack of scientific knowledge of the forces which bear from all directions, on the demand and delivery and consumption of medical care, can be detrimental to the morale of the public and to the staff of the National Health Service; and ultimately to the quality of service.

II. Communications: External depend on quality of internal

It seems to me that in relation to the problems of communication the National Health Service has the two heads of Janus.

On the outward-facing side lie ranged the relations with the public and the bodies and individuals sensitive to the instruments of the mass media.

The other head must brood over the network of communications linking the welter of individuals, the independent and semi-dependent health service authorities, professional and staff organisations and the like, concerned with the logistics of bringing medical care services to patients.

The *outward* face has a wry, occasionally angry, more often resigned look: the *other* must perpetually shudder at what it sees.

On the external side, the impression given by the mass media is undoubtedly one of over-simplified presentation of the issues to the public and a distorted picture of the whole. This is understandable given the limitation of space and time and the fact that drama must be more tempting to portray than solid service.

At times it seems as if most of the public debate is carried out by assertions, mainly by headlines and slogans. Television is no whit better than the written word: indeed who cannot but echo McLuhan, the prophet of modern communication theory, and feel with Romeo:

"... but soft
What light through yonder window breaks?
It speaks and yet says nothing."

Every shortfall in some or other aspect of health services seems to be ascribed to some fundamental flaw in the vague entity called "the National Health Service". The imminent "collapse" of a sickly National Health Service has been gloomily predicted for most of the past twenty years. It says something for its constitution that the patient has survived and flourished.

Fortunately, the public are not so easily fooled on performance. Their individual experience brings a better perspective to the somewhat distorted picture so often presented through the mass media; and Janus' occasional anger soon subsides into grimaces of distaste.

The outward-looking head of Janus includes the politicians in its field of view as well: for it is unrealistic to believe that health services can ever be taken out of the political arena. The somewhat comforting factor which makes for stability is that any scheme of health services is unlikely to deviate much from the ruling ethos and the social, political, cultural, economic, demographic and educational forces which obtain in each country.

Still, some confusion in atmospherics would be removed if some distinction was made between those things which are Caesar's, which are of the essence of politics and those which are not. It is clear the Minister has to take many decisions as a Chairman and Managing Director; but equally, he and the Government of the time must take decisions which are all to do with politics and consequently invoke political reaction. The most obvious of these is the social priority to be given to health services and the way in which the selected priority is reached. Only confusion can arise from appeals to break the National Health Service out of politics as if there was a simple choice. Instead the call should be for a cool discrimination between political and management issues.

While politicians are always likely to be sensitive to the organs of public opinion they are also, in this semi-scientific age, likely, I hope, to be interested in facts, in rational appraisals of the situation, and in a close analysis of the key issues of the moment, in short, in ideas. For this, essentially they must look to what comes out of the internal communication system. This is why the shuddering face of Janus is no joke. The cause of over-simplified Press comment or vapid or wild political observations about the lines of possible reform to achieve some vaguely defined improvement directly derives from the poor quality of the internal communications of the system and the general poverty of facts in use in the public debate.

III. Bad communications and morale

Dr. R. W. Revans some years ago first drew attention to the results of poor

communications in hospitals—in particular to its effect on morale. Communications do not wholly fail because of a lack of adequate *contact* between people in health services. There are indeed signs that there is now a better appreciation than ever before, that it is a Greater Medical Care Profession that is concerned with health: that for that Profession the inevitable specialisation demanded by the scientific and technological bias of medical care needs synthesising.

A major part of the blame lies *first* in the inadequate appreciation of objectives at all levels of the National Health Service, which must be clear-cut if there is to be effective management, and *second*, in inadequate information about the extent to which they are being achieved in performance.

It has become a cliché—a basic platitude—to insist on better management, just as it is for better conditions for nurses, for better facilities for continuing and further education: and above all for better facilities for those who are being treated by the health services.

The move of medicine towards science and technology has introduced problems which demand a managerial revolution which will take into consideration all the various advances of knowledge in the psychological and social sphere. What the National Health Service has to avoid is a backward move towards some out of date line management concept. It is urgently necessary to develop a special kind of *managerial and social philosophy* in looking at a complex social service such as the Health Service where the problems are overlaid by professional ethics and aspirations which may be at odds with public attitudes and public protection policies.

It is not for me to refer to a paper the colour of which seems, perhaps significantly, to be somewhere between red and blue (I hope not too pastel a shade), but it seems that we are going towards a period when there is likely to be a more general agreement than ever before that we should replace the present three-part system by one of all-purpose authorities concerned with all the basic armamentarium making up health services.

This seems a sensible move: but it would be to ignore reality to assume that by the stroke of a pen overnight all the problems of integration of the hospital with the general medical and health authority services, of demarcation disputes within and between professions, and of settling priorities concerning care and cure are going to be solved. What both the politicians and the management of the National Health Service have got to look to—whether there be marginal or radical structural reform is whether the internal network of communication upon which the achievement of the objectives of a complex, comprehensive service depends can respond effectively to the functional demands of today, by putting all the real issues in perspective.

IV. The inter-relation between Philosophy, Administration and Communication

To answer this question we have to look more frequently than we do at the *philosophy* of the National Health Service, the *administrative* theory of the steps taken to apply the philosophy and the *communications* theory on which the administrative theory so much depends. We all tend to assume we know all these issues as they affect the National Health Service, but do we? One or two of the more salient features need to be looked at from time to time.

The ruling universal social hypothesis regarding health services is that the whole population has a basic right of access to the best modern medical care. This theme, or some variation of it, is the guiding light to public policy on health

services in all western societies today. It does, of course, conjure up many things to many men and each society interprets in its own way the range and degree of integration of services it needs and how the costs should be borne. At present, in Britain, it is a basic assumption that a person who is sick, or believes himself to be so, has a right to consult a doctor *free of charge*. The State has a duty to make it possible for the demands for medical care on it, including prevention, to be met.

Most health care systems tend to be evolutionary but the one major social revolution which the National Health Service Act introduced was the right of everyone of access to a doctor free of charge. Any right to subsequent *treatment* depends entirely on a doctor's decision. This was, of course, an enormous radical change and it places great responsibility on the individual doctor. On the other hand, although sometimes one would almost think it was a "sucker" growth instead of part of the tree, the Act itself did make provision for access to consultation and treatment for which charges could be made. All policy and administrative and planning policy particularly for the National Health Service, should rest on these foundations.

Yet nothing is immutable and events and experience do change attitudes; which postulates some provision for a review of the various principles which lie behind the National Health Service to distinguish practice from theory. I do not wish to develop this theme, only the principle of continuous review as a safety valve, for we must assume the necessity for debate on philosophy as part of a lively interest in health services; and as a professional optimist I believe truth will prevail in the long run.

Again, what is our perception of the National Health Service in practice against an administrative theory which basically will apply the philosophy and maximise the initiative, the energies, the administrative skills of the population: and at the same time cherish and utilise the generosity which moves so many people to wish to do voluntary work in the health field?

It is odd that with so much platitudinous talk about management we have had no administrative theory for the National Health Service dealing explicitly and in detail with issues which are the very stuff of management, for example:

- (i) the means of achieving and monitoring quality of performance;
- (ii) the way in which priorities for development are settled;
- (iii) analyses of the effectiveness of prescriptive screening measures and projections of the cost of the development of these and their effect on demand;
- (iv) on educational policy related to service and productivity;
- (v) the effectiveness of assets in use;
- (vi) the relationship and gearing of capital to revenue expenditure;
- (vii) the present effect of a possible increase in those services which can be the sources of more finance including private practice; and what such an issue will mean in other ways;
- (viii) the reaction and relationship of all the individuals, institutions, professions, etc. within and without the National Health Service, within a manpower policy.

Such an administrative theory *must* indeed be developed to fit the philosophical framework; for only so can we stimulate sensible discussion separately in the areas of choice which are political and managerial to achieve the main objectives of deploying our resources to full advantage in maintaining and improving existing services, and of making soundly based decisions for development.

What about the *communications theory* to link all the institutions in the

system? Such a theory must provide not only for the transmission of ideas and knowledge from the Ministry: it must also have a secure base at the local level to avoid the insecurity of frustration and false perspectives. It must therefore be two-way. Indeed the administration theory depends on the communications theory, the objective of which must be to maximise effort and ensure the optimum deployment of resources. The ideal outline is easy to see, and to draw it is to reveal the gaps in the present form.

While there must inevitably be a fair measure of centralisation of policy, it must be a central theme that there should be as much delegation as possible, so that the actual management and the initiative for development should not only be encouraged at the area and local community base, but that the encouragement should take the form of satisfactory practical incentives. No one is likely to cavil at the principle that there must be adequate safeguards at the level of government, to ensure that proper targets are set—and achieved—with adequate standards. But the Ministry of Health must ensure that none of its actions or practices offer any excuse on the part of the lower-tier authorities to slough off the real responsibilities.

Again, to ensure as much as possible that policies are securely based it must be a principle that maximum use must be made in the system of as many existing responsible institutions as possible, including the independent voluntary ones. We have very many ancient organisations and educational institutions, the worth of which it might be tempting to dismiss as too rooted in the past to be of any great relevance to the problems of today and the future. This is false and dangerous thinking. By all means we must not bow down to the more worthless or reactionary traditions; but modernisation can depend as much, if not more, on evolution than revolution; and so do not let us create tensions which can be divisive and disruptive, and lose potentially valuable bases for protection of liberties, and against the dangers of bureaucracy. Equally the newer voluntary bodies such as the Hospital Friends must be nurtured and used as much as possible to mobilise individual voluntary effort.

Alexis de Tocqueville, writing 130 years ago at a time of world upheaval not unlike today, enumerated some principles about England relevant to our situation today. "Decentralisation, like liberty, is something which the leaders of the people always promise and never give. To get it and to keep it, the people must rely on its own efforts and if they have not the taste for it there is no cure for the ill".

De Tocqueville also noted that in England the spirit of individualism was nurtured through so many clubs and other associations to deal with specific problems, that the organised political parties were called to concentrate on big questions of national policy. These principles surely have a lesson for the National Health Service.

V. Protection of the Public

There is perhaps one other, almost over-riding issue concerning the need for better communication in health services which poses political, administrative and professional problems. That is the protection of the public which, while by no means gullible and indeed it is almost better informed about health matters than ever before, is still at its most vulnerable concerning matters of health.

One of the major developments over the past few years has been the emergence of consumer protection and advisory groups. I was fascinated to see a copy of the letter to President Johnson from the Secretary of Health Education and

Welfare of the United States Government, written on June 14th, submitting a modern plan of "organisation to achieve the most efficient and economical operation of the whole programme of the Federal Government". The first recommendation of the Report highlighted in this letter was "the creation of a Consumer Protection and Environmental health service as a unit of the Public Health Service". This indicates the strong current of interest of Americans in quality of care. It does, however, raise the questions "What is the position here?" and "What is required?"

The majority of the public have not the habit nor the means of taking a critical attitude to the performance or output of the health services. Only the small minority with access to information about performance are aware that the quality of care varies according to organisation and experience of medical institutions and of doctors. This indeed must always be one of the major reservations to the "market" theory of health provision. (By the same token if a "market" was ever developed for private practice it is almost certain safeguards would be necessary. Would the development of controls on the American experience be necessary here? How would these affect professional outlook, etc.?) I am personally very sceptical about the pedlars of the "market" theory, especially those who fail to discuss these key issues, which pose great professional questions regarding "control".

Of course more surprisingly, many of those dealing directly with medical care are also unused to questioning their own objectives except in fairly vague terms. For instance, transplant surgeons may be reluctant to appraise results in terms of life-expectancy; advocates of universal screening may hesitate to calculate the savings in future medical resources which might arise from selecting for priority attention a limited high-risk age group. Because there is no incentive here, administrators concerned with comprehensive health rarely weigh the capital cost of some improvement against revenue savings; or of an anti-smoking campaign against the long-term savings in health expenditure.

As a result of these uncritical attitudes, the various objectives of medical care are seldom clear; and even when they are clear, no methodology or machinery has been created for a comparison of their results—in order for instance to decide whether funds should be allocated to a preventive care campaign or to a clinic for supporting care.

Development often proceeds on the basis of subjective judgement and this is favouring a bias towards the more obvious technological rather than clinical care and therefore a neglect of the care and treatment of mental, chronic or congenital handicap.

Many who are starting to look more deeply into these issues which are very necessary for the future, can see that the allocation of scarce resources to certain classes of patients is often decided by chance rather than plan, and the structure of much of the health services is shaped by irrational competition between its parts.

Improvement in the position could be sought first through a thorough discussion followed by the study of medical objectives and results, and then an evaluation of alternative operational procedures for the same end. The dissemination of objective data on these issues should be the ultimate goal so that the public as well as health workers may be better educated to the issues.

VI. Need for special measures

I have tried to draw attention to the present lack of definition and perspective,

and sometimes confusion, about objectives and to what extent they are being achieved; also to the need for a wider and better dissemination of knowledge about health services. This situation I feel calls for extraordinary measures: for somehow or other we have got to get the picture right.

It seems to me there is need for the development of a series of special, new arrangements, preferably independent and certainly apart from the executive machinery of government, although closely allied to the National Health Service, for:

- (i) the improvement of knowledge and understanding about the major issues concerning health services, their organisation and delivery;
- (ii) for the continuous close analysis of ideas which grow from the application of knowledge to the logistical problems concerning the availability of services;
- (iii) the improvement of means for exchanging, conveying and imparting such ideas and knowledge and so for protecting the public as individuals.

It might be held that the elements of these arrangements already exist in the Central Health Services Council, but I wonder whether that body with its history of dependence on the Executive for staffing, etc. could ever develop appropriately.

In the event it might be useful to outline what is necessary. To some extent the way is already charted by what obtains in *clinical and scientific medicine*, viz. the encouragement of varied research led by an independent, specially geared Research Council; good outlets for the publication of learned papers; the discussion of these and other results at recognised forums, which also double as the necessary *media* for continuing education; the recognition and encouragement of applied research.

In the case of *medical care services generally*, there is no research body which leads in the field, and the standard of research is regrettably neither high nor geared to recognisable policies. There has been a modest increase in research in recent years, but a close study evaluating what has been published might lead one to conclude that we need better, rather than more, research. This postulates the need to monitor research to give it a proper rating—and discipline. There are no real forums, specially geared to structure the close reviews which the application of research needs as a prelude to wider discussion. The kind of continuous private policy seminars which the Nuffield Provincial Hospitals Trust puts on from time to time for its own purposes, for reviewing such questions as screening policies, computers in the service of medicine, maternity services, geriatric services, etc. suggest an intensive method of review which is capable of being applied on a larger and wider scale for review and education.

Applications of successful research through experiment and demonstration are haphazard and few, and rarely have in-built evaluation. Again, this is because there is no machinery for recognising the value of positive research and testing it by an applied phase. Nor, as has been shown by the evaluative studies of screening sponsored by the Nuffield Provincial Hospitals Trust, is there any effective machinery for giving scientifically based advice on many developments, even to the Ministry.

It is not enough merely to have *centralised research groups* at the Ministry, either pre- or post-Fulton types. Rather should one make no small plans and proceed to set up an independent *Health Services Research and Educational Corporation* to be concerned with the dissemination of knowledge and ideas as

well as research and its application. It should also have an arm concerned with the appraisal of such special services as screening procedures, etc.

Again, each Regional administrative authority must be encouraged to have its own *Research and Intelligence unit* as a means of educating itself and its constituent bodies, and dealing with the problems which face it, and to follow up research and development.

At the local level, there are difficulties with the management committees as presently organised; there is no effective machinery yet for the mobilising of the skills, talent and experience of the group with the highest intellectual potential operating in the health services—the clinicians who play the decisive part in therapy and care, the organisation of which is the very stuff of medical care and management. Yet it is an astonishing thing that the broadly constituted Working Party on the Organisation of Medical Work in Hospitals, which urges a modest change in arrangements, which will make it possible for clinicians to have a better-briefed say in affairs, is in certain quarters looked at with suspicion.

There is also a need for *institutions outside* but in effect, because of some special position, playing some part in the National Health Service, to be encouraged to feel they are participating effectively. Such institutions must be helped, if necessary financially, to promote better research and better information.

Indeed the ideal communication theory must include the principle that where a public service is involved one must provide against the possibility of stifling bureaucratic action. To this end maximum use must be made of as many voluntary independent institutions as possible and their worthwhile developments must be encouraged. As a matter of policy, I have never believed too strongly in the theory that to take money with no more strings than one should use it well, ties one to the giver's chariot wheels. In the parable of the talents there were, after all, no strings attached. On this theory there is no reason why any governmental policy for research should not be as much as possible through independent institutions. The monitoring of the use of talents so given would in the long run be an indication of the worth and effectiveness of such institutions.

It may seem rather outrageous to suggest for example that the British Medical Association should get some government money for research which would conceivably be used to extract more money from the health departments. Yet if any official body outside the machinery is to play an effective part in affairs it ought to be supported in some such way. It would be a tragedy if any such body founded its stand concerning some issue of paramount importance, on research which is inadequate, because it could not afford anything better.

Relations between the *health authorities and the public* have been a neglected field. It is really not wholly a question of public relations, although I sometimes feel it might be useful to establish one or two annual fellowships to allow journalists—and television producers—to spend perhaps a year with the National Health Service and get a feel of the real problems which are dramatic enough.

All health service authorities must be committed to try and build communications with the people of the areas in which they serve. The form they take must vary from place to place, but it is imperative that as part of health education they have a duty to explain to the people at large the many calls on the health services and the way in which the services ought to be used to personal advantage. This is a challenge to the energies, to the initiative and the talents of all local bodies concerned with health.

It has been remarked recently that most people are hardly conscious of belonging to a society, the government of which is remote and frequently illogical in its actions.

Surely democracy does not only mean the casting of votes; it means opportunities to participate. The public recognises through experience that the National Health Service provides a good service. Basically that is because the personal contact between doctors, nurses and others coming into direct touch with patients is excellent. At the next level, that of the institutions and the community in general, it is doubtful whether communications are as good.

One part of the National Health Service was experimental, namely the system of appointments to Boards and Management Committees. When it was first proposed it was attacked as being something foreign to democracy. On the eve of the Maud Report it might be appropriate to point out it has not worked to the detriment of democracy: and, indeed, there is much to be said for it, for it has brought into the hospital sphere an array of talents that would be denied it under a more conventional system. What one must avoid at all costs is narrowing the base at local level of interest in health services. The recent circular, if it means the end of House Committees in hospitals, introduces a danger to communications down the line. No one will dispute the need for good sharper management, but surely good management would never put trivia before any kind of committee in any case. Hospital authorities must have as many terminals in the community as possible to enable people to understand what is involved in plans for health services; otherwise there is likely to be an ever-increasing scope for "them and us" charges, from a public becoming ever more aware of its rights and anxious about its health.

Professor Crick has recently commented that government must, by great effort and thought, be made more plausible, open, plain, responsible and, therefore, effective.

"The greatest restraint on any government or any agent of it is the same as the greatest power behind any free government, the knowledge that people know, or could know roughly, why it is acting as it does. The theory of free communications must supplement, not destroy, the insufficiency of representative participation."

This is particularly applicable to the National Health Service.

Of course *free communications* have their own built-in dangers which have to be guarded against. One of the features of the last few years, and it is unlikely to diminish, is the plethora of Committees of Enquiry, some of them more strongly based than others; and the publication of a mass of reports on research, some of which are more valuable than others. A question which never fails to bother me is how people in the National Health Service can distinguish the good research and the good recommendations (or the good committees) from the bad. Indeed for this reason alone there must be better means for distinguishing the good from the bad prophets.

At the same time we need to hammer out a better and more disciplined convention of conduct for research and committee reports. No Committee of Enquiry, and that includes Royal Commissions, should be allowed automatically to disperse at the end of their period of enquiry. It is extremely important that their period of existence should include a spell during which they should have to explain to as many people as possible who are likely to be affected, what in fact they are trying to do and what the bases of their recommendations are. I am sure many people, not just those in the Postgraduate Institutes in London,

would like to hear some of the reasoning of the Royal Commission on Medical Education behind some of their recommendations.

VII. Need for National Health Service Forums

To bring in the kind of arrangements I have sketched will not, of course, be easy.

Apart from the idea of the establishment of a Health Services Research and Education Corporation and more Research and Intelligence Units, it demands a new look at the better education of those concerned in medical care and methods for discussing ideas and disseminating knowledge, not only within the National Health Service but to the public.

We need to develop more forums as part of the National Health Service. At the national level there should be at least one Centre for Advanced Studies for the Health Service, where people can be invited to come together in selected groups. Such meetings will have to be carefully prepared and structured. The participants will be directly concerned to analyse and discuss the important problems of the day and look afresh at the major problems with which they may not personally have to deal, but on which their particular function has a bearing. It seems to me that the medical profession particularly must play a leading part in developing the particular idea of a National Forum. Is it too much to hope that at the national level the Royal Colleges, acting together, may not see in this some function for them in the future?

At local level, the increasing number of medical centres brought into being for continuing medical education seem to be ideal forums for extensions of the idea.

VIII. General Conclusions—No Simple Solution

Thus it is that in the case of health services it seems to me the reform of the medium, i.e. the superstructure, is certainly not the whole message. The message for health services is contained, if not buried, in a totally inefficient internal communications system, which results in a poorly expressed and understood philosophy of what the National Health Service is trying to do and what it is all about, and in an inadequately expounded and applied administrative theory. Above all there is no simple solution to the problems which arise from the heterogeneous nature of the units making up the Service and from the inter-institutional and infra- and inter-professional relationships.

Anyone who tries to expound one politically or administratively must be looked at with scepticism: for the only sure way is through improving the means for better knowledge and understanding.

"Evil communications corrupt good manners"—and we all know that William of Wykeham's dictum about manners is as applicable today as it was six hundred years ago.

* * * *

Lord Amulree, opening the discussion on Mr. McLachlan's paper, reminded people that the patient was the most important person in the Health Service. The best possible communication had to be established between patient and doctor, whether in general practice or in hospital. There had been failures in such communications in the past and these had been responsible for things going wrong. It had been found that generally the larger the hospitals became the more blameworthy they were in this respect; but he exempted junior members of the staff from his criticism. Lord Amulree said that an example of the good that

resulted from proper communications was to be found in the teaching hospitals, where patients, because the position was clearly explained to them, were generally only too willing to co-operate in student lectures.

Communication between medical staff and students also needed to be improved. The professorial unit system had been primarily intended for teaching purposes, but now a lot of time was being spent on research. We must not concentrate on research at the expense of teaching and that meant communicating properly with students. A great deal of good would result. There was also much to be done to improve communication between senior doctors and their juniors. Where communication was good, where the young doctor was encouraged and helped, there was less trouble, less feeling of frustration and probably less desire to emigrate.

There was a clear demand for good communication between the general practitioner, the local authority services and the hospital, particularly while the tripartite administration existed. This would go a long way to ensuring that the patient received the best care possible. Indeed given good communications, it did not seem to matter a great deal from the point of view of the patient (although there were other considerations) whether the Service was changed from the present tripartite structure or not.

Lord Amulree concluded by saying that it was important not to forget the valuable, complementary role of the voluntary bodies. They could, however, only play their part if communications between them and the statutory bodies were not neglected.

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In the general discussion which followed, it was stressed that it was important for each individual to consider what contribution he or she could make towards improving communication. It was no use simply passing declarations at meetings. Individual ward sisters, district nurses, etc., had to make practical contributions. Tragedy could result from a breakdown in communications.

The Department of Social Medicine at Guy's Hospital had recently undertaken a survey on the attachment of local authority staff to general practice. They concluded that the attachment had brought about increased contacts and mutual understanding between all concerned. This tallied with the findings of research carried out by the Queen's Institute of District Nursing which had shown that, in contrast to the co-operation found in good attachment schemes, many doctors were indifferent or hostile to the local authority health staffs and, indeed, did not know what their functions were meant to be. It appeared that general practitioners and hospitals needed to be made more aware of how the district nurse and health visitor were trained and of the full range of skills which that training provided, so that both could be employed to the limit of those skills. Few consultants seemed to regard the home as a proper place for treatment of certain diseases, particularly in children. There could be no early discharge scheme from hospitals without a strong local authority nursing service working in close harmony with the hospital and the general practitioner. Some progress to this end had been made. Basic nurse training now included an option to take district nurse training. Health visitors could now work in paediatric wards, premature babies could be discharged to the care of a local authority premature baby sister and domiciliary midwives could now participate in the birth of a child in hospitals or general practitioner units.

Other speakers referred to the value of nursing attachments. They could

evolve further and there could be delegation of some nursing duties to auxiliaries, thus freeing the nurse for more skilled tasks. But one of the greatest benefits to be derived from attachments was good personal relationships within the team and, through members of the team, with other workers. Dialogue was better than monologue and the best dialogue was that between people who knew and understood each other.

Members were told that the Health Education Council was aware of the need to sponsor research into the methods of changing attitudes and behaviour. Health education had been referred to by many speakers and it should be known that the Council, although it had been in existence for only six months, had already embarked on research programmes.

There was a call for an independent body to concern itself with research into administrative practices. Any such body should be thinking ahead about where the Service was going, what kind of administrative practice there was going to be, what kind of administrative theory must evolve and, consequentially, what kind of communication system would be appropriate. It was not sufficient to be concerned only with the present.

One speaker said that it was axiomatic that the day of the individual in clinical consultant practice was over. To be effective, therefore, the consultant had to be able to communicate. Unfortunately, many found difficulty in doing that and it was for consideration whether a training programme was needed to teach future consultants what was involved in medical administration and communication with other groups.

Speaking of the methods of communication, a member said that although he regarded his pen as his most important medical instrument, personal contact was much to be preferred. A general practitioner had personal contact with his patients, his team if in group practice, the other branches of the Health Service and the other social services. These contacts were time-consuming; failures occurred because insufficient time was given to communication; but there never seemed enough time to do all that was required such as listening to patients, explaining things to them and visiting them in hospital. Help could be obtained by using secretaries, receptionists and dictating machines, but time would always be in short supply and priorities would always have to be established. The first claim was anything which concerned the patient's welfare.

Other members stressed the importance of making the general public aware of new developments. No real effort had been made to sell the concept of district general hospitals to the general public. Inevitably there was widespread opposition to the closure of some smaller hospitals because the concept of centralisation had not been put over and was therefore not understood. Hospital Boards needed to do more to carry the public with them: the institution of annual fellowships suggested by Mr. McLachlan would be a help.

The patient should be made to feel that he was acting with the Health Service team. There were ample opportunities in general practice to explain how the Service worked, the difficulties which arose and how patients could use the Service wisely and sparingly. Most people were sensible and responsive, if they were given a chance to play a part in the decisions being made on their behalf.

Further reference was made to the importance of building a good system of internal communications between all sections of the Health Service. Good external communication could only develop if internal communication was working. Each individual ought to be made aware of the importance of his work in relation to the whole Service and of the needs of the patients and how those

needs could be met. What he observed he had to communicate. The regular written communication served a purpose if it were written with the person receiving it in mind and if it were properly distributed. Its real value lay, however, in its indication that the originator was anxious to communicate and to be communicated with.

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Mr. McLachlan said finally that he agreed with much that had been said and he thought that people liked the Health Service generally because of the excellent contact they had with doctors and nurses and other Health Service staff when they were ill. What the Conference had been discussing, however, was something rather different—affecting the whole organisation of health services—the imparting, conveying and exchange of knowledge and ideas, which were the most valuable products of men's minds.

CLOSING ADDRESS

The Rt. Hon. Kenneth Robinson, M.P.,
Minister of Health

In her opening address Miss Jennie Lee sketched the early history of the Service; and the principles on which it was established. Sound as those principles were, the costs of the Service proved to be high, far higher than anyone expected. Many of you, especially those already working in the health and welfare services in 1948, will have listened to Dr. Yellowlees' lucid exposition of the difference between need and demand with wry smiles; this was a classic occasion where an attempt to measure need by apparent demand went sadly wrong. We learnt our first lesson then: the provision of a universal and comprehensive service does not in itself lead directly to budget economies by improving the health of the nation in succeeding years. The infant who survives his post-whooping cough pneumonia because of the timely use of antibiotics may well live to become the older man, crippled by chronic bronchitis, ill for months each winter and requiring increasingly frequent drug therapy. What we must not forget is that between the infant illness and the old man's slowly progressive disease, may lie many years of healthy and happy life, and service to the community. Our Health Service costs inevitably increase but nationally we benefit from having a population which is the more healthy and active. Few of us here would, I think, wish to return to the pre-war state in which large sections of the community were unable to afford proper attention when they were sick.

Our immediate concern in the late forties and early fifties was to keep the Service running, and then to raise its standards in those parts of the country where it was poorest. It is hard to believe it now, but at that time there were parts of this country where a medical consultant or a pathologist was never seen; and in one area patients were being nursed in a building described, and in hardly flattering terms, in *Oliver Twist*; while in another a chronic sick unit was once a prison for French prisoners in the Napoleonic wars. I do not deceive myself that we have yet achieved uniform quality of service throughout the country, but it is fair to say that we have made greater strides towards a decent standard everywhere than would have been possible without the National Health Service and thus without the capacity to plan.

Later in the fifties our attention came to be increasingly focussed on improving the lot of those groups of patients, the old and infirm, the mentally sick and the mentally and physically handicapped, who had previously been given little or no priority.

It was not really till the sixties that we were able to consider the implementation of new policies for the provision of hospital and general medical care, and to redefine the role of community care in treatment as well as in preventive medicine.

The concept of the district general hospital became accepted and the first Hospital Plan was published. The health centre programme, although its origins can be traced in the Dawson report half a century ago, has only taken on reality in the last two years. The Mental Health Act of 1959 opened the way for far greater involvement of the community health services in the prevention and treatment of mental illness, and the local authority plan represented a first attempt to provide uniformly high standards of local authority health services.

This Conference was primarily called to bring together some of those working

in the health services who are specially concerned with the sort of care we should be providing in the seventies. It is easy for a central department, largely involved with the day to day problems of so vast a service as this, to let today take precedence over tomorrow, the urgent over the important. Yet all of us are aware that, as Galsworthy wrote: "If you do not think about the future you cannot have one".

Of one thing we can be quite certain: if the last two decades are any guide, in 20 years from now the needs of the population for medical services will be very different from what they are today. Many of today's medical problems may have become interesting historical events, while other conditions to which we have given little or no thought will have increased in prominence, just as coronary infarction, once a comparatively rare diagnosis, is now a major killer in the 40-60 age group. At the same time the seemingly trivial problems that are ever with us, mildly debilitating and non-fatal, may still be plaguing us in the 1990s. Not many would have forecast a quarter of a century ago that we would still be unable to prevent or treat the common cold in the closing years of the sixties.

Professor Butterfield outlined the shift in emphasis from infectious and deficiency diseases to the chronic degenerative diseases, whose basis is laid down in early adult life but whose effects are postponed until decades later. Much of this disease is preventable, although perhaps not every one of us is prepared in our youth to live the sort of life we should if we are to remain healthy in our fifties and sixties. The role of health education is crucial in ensuring that we know what we have to do to remain healthy and in persuading us to act on that knowledge.

Unless we can to some extent foresee the future we cannot plan how to deploy and redeploy our resources to meet it. Inevitably there is a time-lag between the emergence of a new medical need and the development of services to meet it, just as there is a time-lag between the decline of an old need and the curtailment of the services originally provided to deal with it. Fortunately, the British are great innovators and because of the powerful vocation among all Health Service workers to identify need and then to cure it, there has been a steady adaptation of existing services to meet new needs as they arise. Indeed, one of the most striking features of the National Health Service is the extent to which buildings are being used to provide services quite different from those for which they were originally planned: the TB hospital which now houses an intensive care unit, the children's long-stay hospital converted to a preconvalescent unit, the central sterile supply department set up in a disused ward, the almost complete change of function of the infectious diseases hospital. One cannot fail to salute the imagination and enterprise that has gone into these adaptations, but we must at the same time recognise that people who devote their lives to the service of the nation's health deserve to work in purpose-built units and not in the institutions built more than a century ago for a quite different purpose. In those days the general hospital was usually designed to nurse the sick poor, not to give active treatment to the whole range of acute illness.

Unfortunately, the National Health Service inherited many old and out-of-date hospital buildings. Indeed, about half of them dated from the nineteenth century. But it was only a very few years ago that enough capital began to become available for an effective attack to begin on this obsolescence. In the last few years the hospital building programme has shown a quite remarkable growth. This year we expect to spend about £96 million, almost double the

amount spent five years ago and five times that of 10 years ago. The Government have given the highest priority to hospital redevelopment and new construction.

I should like also to emphasise the importance of that other building programme which will inevitably lead to a major change in Health Service provision in the next few years. At the end of 1964 only 21 health centres had been built in England and Wales since the appointed day. Since that date, four years ago, a further 37 centres have been built, 67 more are under construction and 86 are in an advanced state of planning. The acceleration of the health centre building programme can best be seen by showing the growth in capital expenditure in this area: in the 10-year period up to 1965 loan sanctions for health centres were averaging £70,000; last year they had already reached £2 million.

Dr. Reid has outlined the revolutionary changes taking place in this field, with the build-up of community health teams working together in purpose-built centres. Some of these centres are provided by local authorities, others by doctors themselves with or without the aid of the General Practice Finance Corporation. By 1970 we can look forward with some confidence to the existence of some 200 health centres serving the needs of more than 1,000 general practitioners, working with nurses and health visitors, and in many cases midwives and social workers, and serving between 2 and 3 million people. Many purpose-built group practice premises will house similar groups. No one can doubt that this is the pattern of the future; it is the pattern of grouping and the support that matter, not so much ownership of premises. As this pattern spreads, the status of general practice must inevitably rise, and its popularity among our newly qualified doctors cannot fail to improve.

Both the district general hospital building programme and the health centre programme will lead increasingly to the concentration of services. Concentration is not a new principle: within each hospital it is already taking place. Acutely ill patients are being nursed in intensive care units with special, costly equipment for monitoring and resuscitation and highly trained nursing staff, while convalescent patients are being cared for where they are less disturbed by the intense activity that inevitably surrounds emergency care. Locally, each district general hospital concentrates within its bounds acute services for all types of illness—physical or emotional—for a defined catchment area. Regionally, super-specialties such as cardiac surgery and renal transplantation are gradually being concentrated at selected district general hospitals. We are learning to concentrate supporting services in sub-regional centres.

Concentration is efficient and makes economical use of scarce resources, both human and physical. But if we are to concentrate our services, both those who work in them and those who use them must travel further. This is regrettable but inevitable. Ideally, each of us would like to have a health centre at one end of the street and a district general hospital at the other. But none but the very foolish when really needing expert care would prefer a lock-up surgery and a cottage hospital within walking distance to a modern district general hospital a dozen miles away and a health centre within five miles. We cannot build the new and keep the old.

Nowhere are we so ambivalent in our desire for the best service at our doorstep as in the provision of services for accidents and emergencies. All of us want two things: on the one hand somewhere close by where we can go at any time of the day or night, with the finger that the lawn mower has nibbled, the boil that gets bigger instead of smaller, the child who has spilt a cup of tea on his foot;

and on the other hand we also want a big, modern hospital staffed night and day by doctors and nurses equipped with every modern device, where the ambulance will drive us after a pile-up on the M1. How many of us pause to consider whether as a nation we can afford both and, indeed, if we could, whether both could ever be staffed?

This brings me inevitably to the subject of resource planning. Two highly experienced speakers, Dr. Davies and Dr. Yellowlees, have already dealt with this subject at some length and what I have to say is no more than a brief addendum.

There are many demands on the Health Service that cannot be fully met, and not all of them should be fully met, since the lesson of all advanced countries is that demand must be expected always to outrun supply. In fact, the volume of service provided expands because of increased trained staff in all the health professions every year. Our most urgent problem is to secure that the maximum effort the health services can achieve shall be directed to those ends which are most worthwhile. We cannot pretend that we achieve that. We could more nearly do so if the available resources were better deployed. Hospital work could be organised more effectively by a corporate effort of the professions in the hospitals more closely adjusted to the needs known to their colleagues in the community. Community services could be improved by regrouping upon general medical group practices, whether in health centres or not. The public and the professions will only achieve what both want if the one concedes the convenience of the proximity of the single-handed doctor for the different conveniences and the improved efficiency of an organised group and the other concedes the luxury of isolation in return for the professional advantage of group membership.

Obviously, one standing need of any health service is more money, but there is not now, nor will there ever be, as much money as the professions could usefully employ. It follows that they must make better use of what can be provided. Better organised professional work cannot overcome an absolute dearth of resources, but it would greatly improve the use of what we have and demonstrate the justice of any claim for more. The responsibility of the health departments is not merely to provide resources, but also to foster their more systematic use.

To move a resource from a service already provided to a new one must inevitably mean curtailment of the original service. But we have heard earlier of the difficulty of distinguishing need from demand and we now know that there is no finite limit on the latter. What we have to decide, therefore, is whether our resources are best used as they are, or would be better used in some new way to achieve a different balance between our objectives. Nobody can make this decision without having these objectives clearly in mind.

For any service to reach the best decisions on the choice of objectives and the deployment of its resources it must have an appropriate organisation. My proposals on reorganisation of the present administrative structure of the Health Service will shortly be published in that much talked of and, I think, greatly anticipated Green Paper, for consultation and discussion. My proposals will only be tentative and will almost certainly be changed in the light of the comment and discussion which I hope will follow publication. At roughly the same time we will have the report of the Seeborn Committee on the local authority personal health services to consider, and later, the report of the Royal Commission on Local Government. Both these reports will carry implications for the present organisation of local authority health services.

Discussions of the use of resources inevitably leads on to that most precious of all our resources, the human one. I am glad that we were able to devote a whole morning to this subject; so much time and thought has been given in the past to economies in the use of money and of buildings and so little to the people who provide the service to the patient in those buildings. Mr. Bonham-Carter has told us how manpower planning was thought to be unnecessary before the war and that even now it is very much the poor relation of hospital planning. We must all recognise that in fact it is probably the most important single issue which the Service faces today. Unfortunately, it is also perhaps the most complex. Immediately we are faced with a major difference between economic or building planning and planning with people—the units concerned are human beings. They have emotions, preferences, ambitions and families, and deserve—indeed, demand—reasonable consideration. They are entitled to the same loyalty from the Service as the Service demands of them.

The devotion to work and the goodwill of the people at present staffing the Service deserves the highest praise. No other service in this country has been so free from strikes, go-slows and working to rule as ours. Unfortunately, I do not think the reason is because we have always been particularly good employers. In the past, as Mr. Drain has pointed out, the Health Service has been bedevilled by a diffusion of leadership, by fragmentation of professional and technical classes, and by inadequate appreciation of their work. All this is changing, but it is up to all of us to make it change faster.

I will not say we yet have all the answers to the points put from the floor during the discussion. Very few other countries yet have comprehensive health services that we can study. We must find our own answers.

Before I end my remarks on manpower—I would like to mention the increasingly widespread interest being taken in expanding voluntary effort of all kinds. The Health Service owes a special debt to all those who serve the patient voluntarily, as members of Boards and Committees, or in the innumerable other capacities which are so important and so often unsung.

Mr. McLachlan reminded us of the vital importance of communications, a theme which has recurred throughout this Conference. Communications in the Health Service must be three-way. It is easy to remember two of the ways and forget the third. First of all, at all times it is essential to listen to the patient and to discuss with him his care; secondly, co-workers in the same profession, in the health team, and administering the service must be kept informed; thirdly, the general public, the Health Service "consumers" of tomorrow, must know what the National Health Service is, how it is run and financed and the changes it is undergoing as it evolves from a piecemeal, haphazard conglomeration of variegated services into one highly efficient, well co-ordinated, humane organisation.

Communication within the Service is comparatively easy. I mean by that that it is just humanly possible, if we never, even for one moment, forget it.

Outside the Service, communication is far more difficult. Partly it is a matter of education, and I know that the new Health Education Council will have this very much in mind, and partly it is a matter of public relations. We are all of us or we should be, public relations men. It is our job to try to see that the public, through the newspapers or broadcasting, get a true picture of the National Health Service. It is not a Service on the point of collapse, as is sometimes reported, but one that is expanding and improving steadily all the time. You know this and I know it, but the public and our friends abroad might be in

danger of being led to believe otherwise; and I appeal to you as workers in the Health Service to remember that the Press should be assisted to give the public a picture of the National Health Service as it really is, in terms that will make news and be read. Representatives of the Press will, I know, welcome opportunities to see for themselves what is happening, the developments that are taking place, the way problems are being tackled, the new concepts of patient care; and by helping them to obtain firsthand impressions, I am sure they will present a truer and fairer picture of the Health Service than if left to gather opinions as and where they can.

Consider how wide and all-embracing is the service that we give. Last year 5 million people occupied hospital beds, while 31 million were seen as out-patients. Then think how few in comparison the stories of disaster are, and in what a tiny fraction of these there is ever a hint that neglect or mistreatment was intentional rather than accidental. Good public relations start with us, and if we find them less than good, then we must share the blame.

I hope that this Conference will act as a catalyst and that you and all the others who will read the record of its proceedings will continue the discussions elsewhere and use the best of the ideas to improve your own work wherever you can, for the benefit of the patients who are the sole purpose and object for which our Service exists.

I want to thank you for all the help which you have given me in these last two days, just as I want to thank the hundreds of thousands that you represent for the help and support that they have given me and my Department in my four years as Minister. For the future you will, I am sure, join with me in a wish for the prosperity of our Service; and now—forward to the 1970s.